

Race Equality Training in Mental Health Services in England

Does One Size Fit All?

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Contents

	Acknowledgements	4
	Foreword	5
	Executive summary	6
1	Introduction	9
2	The history of race equality training	12
3	Delivering race equality training	24
4	Training providers	33
5	Evaluation of training	38
6	Discussion & conclusions	40
7	Recommendations	44
	Appendix 1 Methodology	46
	Appendix 2 Membership of steering and advisory groups	50
	References	52

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Foreword

The need to improve training in cultural competency as a method of addressing racism was shown in *Breaking the Circles of Fear* (Sainsbury Centre, 2002), *Inside Outside* (NIMHE, 2003) and the *Delivering Race Equality action plan* (DH, 2005). The importance of this training was highlighted by the findings of the *David Bennett Inquiry* (NSCSHA, 2003) and the results of the *Count Me In* censuses (Healthcare Commission, 2005 & 2006).

This report shows that the delivery of race related training in mental health is often patchy and does not always form part of an overall strategy to achieve race equality. Race related training is often the main strategy for achieving race equality but it is seldom subjected to rigorous evaluation. This means that there is no clear evidence of the extent to which race equality training is making an impact on improving services for Black and minority ethnic (BME) communities.

The findings of this report are important. They show that a ‘one size fits all’ approach to race equality training for all personnel in an organisation does not adequately address specific issues related to individual practice or organisational needs. Training for race equality needs to be seen as just one element within the wider framework of race equality. There should be more focus on racial discrimination and everyday practice, and rather less on cultural differences.

With that in mind, perhaps the most important finding of the report is that even where there has been some success in improving cultural knowledge within existing race equality training, there is little evidence that this type of training has had an impact on the experience of service users or on equality outcomes.

This report should be read by all commissioners and providers of race equality training and anyone who has an interest in race related training.

Chinyere Inyama
Chair of Steering Group

Executive summary

Introduction

This report presents both a historical analysis of the development of race related training and the findings of a survey of race equality training in mental health services in England. This is the first national study of race related training in mental health services. The study was jointly funded by the Sainsbury Centre for Mental Health and the National Institute for Mental Health in England (NIMHE) (a part of the Care Services Improvement Partnership [CSIP]). The main purpose of the work was to make recommendations that would inform the development of an effective programme of race equality training.

The historical review showed that:

- ❖ Race related training originated in an era when racism was overt and instituted in law. Racism was viewed as the major cause of race inequalities. As the focus on 'race' became unpopular politically, the concept of diversity was introduced as an explanation for all forms of inequality.
- ❖ Approaches to race related training have been influenced by the changing politics of race relations. The concepts of race and racism have been replaced by culturalism as an explanation for all inequalities experienced by Black and minority ethnic (BME) groups and this has become the central framework for race equality training.

Through a postal survey we elicited responses from 47 training commissioners, 461 employees and 35 training providers. The findings indicate that while the majority of mental health services are providing training for their staff, there is fragmentation and a lack of robust evaluation that demonstrate effectiveness in terms of improving outcomes for Black and minority ethnic communities. The findings suggest there is a need for a more strategic approach and for national standards that address both the nature of training and the selection of training providers.

Training provision

91% of organisations reported that race equality training was provided for employees; 86% said this was for all staff. Training was compulsory in 53% and strongly encouraged in another 28%.

67% of employees said they had attended race equality training in the last three years.

Of the many models of training that are used, the most widely provided were in diversity (86%), cultural awareness (51%) and cultural sensitivity (44%).

The key reasons for providing training were the Race Relations (Amendment) Act and government policies such as Delivering Race Equality.

Training objectives and content

84% of employees and 91% of providers said one of the main aims of training was to improve awareness of race and cultural issues. 80% of training providers but only 33% of staff thought changing behaviour was among the key aims.

The content of training varied widely. It was influenced most by the trainer's own perspectives and the commissioning organisation's requirements.

The most common reported contents were policy and legal issues (88%) and understanding difference (82%). Less common contents included skills for non-discriminatory practice (60%) and strategies for resolving conflict (39%).

One quarter of participants reported that service users were involved in delivering the training.

Training providers

There is no professional body that sets standards for the qualifications and practice of race related training providers. 60% of training providers in our survey had received training in race equality, 54% in mental health care and 40% in training skills.

45% of trainers were independent or freelance providers. 34% reported that they use or have used mental health services.

Evaluation of training

35% of statutory and half of independent sector organisations had evaluated the training their staff received. The main methods of evaluation were attendance at training events (76%) and post-training reaction (71%).

One-third of commissioners said training had had a positive impact.

77% of training participants in our survey reported some positive impact on their work or themselves, but only 48% reported a positive impact on the organisation or service delivery.

Conclusions and recommendations

This report concludes that:

- ❖ Current approaches to race equality training are inappropriate and inadequate in addressing racial inequality in mental health services.
- ❖ Essentially 'training for race equality' should focus specifically on the areas of inequality people experience in mental health services, such as diagnosis, compulsory detention, reducing fear etc., rather than a generic focus on cultural difference or diversity.
- ❖ Emphasis in race related training must be on the improvement of professional practice and not merely the acquisition of knowledge on the cultures of those categorised as the 'other'.

- ❖ Training for race equality should form part of a wider framework for reducing race inequality, embedded within the organisation's clinical governance systems. It should address the needs of the organisation and its staff and form part of a wider framework of reducing race inequality.

Key recommendations include:

- ❖ Fundamental changes are needed in the way that race equality training is delivered.
- ❖ The Department of Health should commission and co-ordinate a programme of work which develops a template and sets national standards for appropriate race equality training, including guidance on the qualification and accreditation of training providers.
- ❖ Race equality training should focus on the development of professional practice emphasising the interpersonal interactions between service users and practitioners and the organisational processes that lead to unequal treatments and outcomes.
- ❖ Primary care trusts (PCTs), supported by strategic health authorities (SHAs), should be responsible for the performance management of provider services in meeting the Race Relations (Amendment) Act 2000 requirements and implementation of the Delivering Race Equality programme, including the provision of appropriate training.
- ❖ The Healthcare Commission should be required to assess race equality training as part of its responsibility for monitoring race equality standards.
- ❖ Organisational policies and plans on race equality, including Race Equality Schemes (RESs), should specify the training necessary to achieve strategic aims.
- ❖ Organisations should involve their frontline staff in the development and implementation of RESs. A real sense of involvement and ownership needs to be nurtured alongside the provision of training and support.
- ❖ Race equality training should not be viewed as a single programme that can be delivered to all employees ('one size fits all').
- ❖ Evaluation should be resourced as an integral part of the commissioning of training. It should be designed to examine participants' learning, behavioural change and the impact on the organisation, as well as their immediate post-training reactions.
- ❖ Training providers should include service users and individuals from BME groups. But BME staff should not be viewed as 'race experts' and be expected to deliver training without adequate training and support.
- ❖ Training should be developed to support service user trainers, particularly in transferring experience into the training setting.
- ❖ The Department of Health should acknowledge the need for and resource further research on race related training.
- ❖ The Mental Health Research Network should incorporate race related training into the research agenda for mental health care.



1

Introduction

Since the mid-1960s, training for staff in public services has been proposed as one of the major ways of improving race relations in the UK. Race related training has its origins in the United States, but was introduced into the UK in response to the racial inequalities experienced by immigrants from Commonwealth countries following the Second World War. Throughout the 1970s and 1980s race related training continued to be advocated in response to concerns about race relations in public services. The Stephen Lawrence Inquiry (McPherson, 1999) gave a further impetus to race equality training. The report proposed that institutional racism was endemic in the police force and other public services and recommended training in racism awareness and cultural diversity as one solution.

Race related training has been delivered in mental health services for a number of years. Responses to the consultation on the Delivering Race Equality framework (DH, 2003) indicated that while some services claimed good practice in this area, most service providers required more clarity and suggested the need for a more co-ordinated and standardised approach.

One of the key findings of the Inquiry into the death of David Bennett (NSCSHA, 2003) was of institutional racism in the NHS broadly and in mental health services specifically. The report indicated that mental health staff did not have an adequate understanding of racism and lacked skills to address racist behaviour and practices. It recommended that mental health staff receive training in all aspects of cultural competency, awareness and sensitivity, including training to tackle overt, covert and institutional racism.

In response to the Inquiry and as part of a wider strategy to improve mental health services to Black and minority ethnic (BME) communities the Department of Health set out the Delivering Race Equality action plan (DH, 2005). It emphasised the need to provide mental health staff with the right skills to deliver equitable and effective care to different racial and cultural groups. The action plan sets out a programme of work to map current education and training, to develop appropriate race equality and cultural capability training, and to produce a common skills set for mental health practitioners.

The Race Equality Training Project was initiated as a three-year joint project between the Sainsbury Centre for Mental Health and the National Institute for Mental Health in England (NIMHE) (a part of the Care Services Improvement Partnership [CSIP]). The outputs from the project were expected to inform the Sainsbury Centre's Breaking the Circles of Fear programme and the Government's Delivering Race Equality plan to develop appropriate race equality and cultural capability training.

The proposed programme of work aimed to map existing race equality training, develop a programme of training informed by the mapping exercise and evaluate its effectiveness. This report addresses the first phase of this work.

Aims and objectives of the study

Aims

- ❖ To review the historical context of race related training by carrying out a literature review.
- ❖ To carry out a scoping exercise to map existing race equality training approaches in mental health services in England.
- ❖ To make recommendations that would inform the development of an effective programme of race equality training.

Race equality training is defined as any training that is aimed at reducing race inequality, including multicultural, anti-racist, racism/cultural awareness, cultural sensitivity, (cultural) diversity, and cultural competence.

Objectives

- ❖ To examine the development of race equality training.
- ❖ To examine organisational support for race equality training.
- ❖ To provide an overview of approaches to delivering race equality training.
- ❖ To examine employees' views and experiences of race equality training.
- ❖ To examine training providers' views of race equality.

Methodology

Detailed information about the way we conducted this study is given in Appendix 1.

The sample selected for the survey component comprised:

- ❖ All 80 mental health NHS trusts and primary care trusts (PCTs) in England.
- ❖ All 25 independent sector adult inpatient mental health facilities in England.
- ❖ Employees who had attended race equality training (1850 questionnaires were sent out in total: 20 copies to each statutory sector organisation and 10 copies to each independent sector organisation).
- ❖ 90 providers of race equality training in England.

Three questionnaires were devised to collect data from commissioners of race equality training, employees who had received training in the last three years and race equality trainers.

The questionnaires for commissioners and employees were adapted from existing questionnaires developed by Tamkin *et al.* (2002).

The questionnaires were refined with input from the advisory group and a pilot study with relevant subjects.

Table 1 shows the number of questionnaires distributed and the response rate.

Table 1: Number of questionnaires distributed and response rate

Sample	No. of questionnaires	Response rate by sector	Total response
Training commissioners			
❖ NHS mental health trusts/PCTs	80	43% (= 34)	45% (= 47)
❖ Independent sector services	25	52% (= 13)	
Employees			
❖ Statutory sector	1600 (20 per service)	24% (= 377)	25% (= 461)
❖ Independent sector	250 (10 per service)	34% (= 84)	
Training providers	90		39% (= 35)

Our survey yielded a 45% response rate from training commissioners in both the statutory and independent sector. It was not possible to identify a random sample of employees who had received race equality training or training providers. Employees were contacted through the commissioning organisations and a 'snowball' (word of mouth) method was used to identify training providers. This resulted in lower response rates and may limit the generalisability of these findings. A further consideration is that the findings of the report are based on self-reported data, which were not verified. The findings of the report should therefore be interpreted in view of these limitations.

Despite these limitations it is, to our knowledge, the first and largest study of the provision of race equality training in mental health services, providing data from the perspective of training commissioners, employees who have received race equality training and training providers.

2

The history of race equality training

Summary of key points

- ❖ The development of race related training in the UK has followed a historical pattern very similar to that of the US.
- ❖ Race related training developed in the US to address inter-racial tensions after the Second World War.
- ❖ The first sensitivity training was held in 1946.
- ❖ The assumption was that racism could be explained in psychological terms.
- ❖ The aim was to transform individual negative racial attitudes through small group confrontation guided by trained leaders.
- ❖ The development of race relations legislation shifted the emphasis from changing attitudes to changing behaviour to meet legal requirements.
- ❖ In the 1980s and 1990s there was a rejection of affirmative action and structural inequality. This led to the development of the diversity model, which emphasised cultural differences as the main source of inequality.
- ❖ Cultural competency developed within the diversity framework and was initially applied within health and social care systems.

Introduction

Race related training emerged first in the US. Its development there significantly influenced developments in the UK, other parts of Europe, Australia and New Zealand. Although there are differences in the social structures and political traditions of the UK and the US, the struggles for racial equality and the response in terms of race related policies and legislation are similar in many respects. This chapter reviews the development of race related training in the US and UK and presents an overview of the differing models of training that have been used in the UK.

Origins in the United States

Policies and legislation on race have characterised the development of the United States of America since its birth as a republic. From the early 1600s, racism in the United States involved the systematic enslavement and segregation of people of African descent. This was justified by the ideology of the superiority of whites and the inferiority of Africans, and was enshrined in law.

This dominant belief was not significantly threatened until more diverse immigrant groups (e.g. Asians and Latin Americans) began to appear in increasing numbers in the late 19th century. This led to policies to limit immigration by barring some groups and placing quotas on others.

In the decade immediately preceding World War I, a pattern of racial violence began to emerge in which white mob assaults were directed against entire Black communities. This led to race riots: the greatest number occurring during and just after World War I. During this period the social policy approach to immigrants was one of assimilation through the Americanisation programme. This promoted training in the English language and naturalisation. The vision of the melting pot approach was that immigrant cultures would disappear or merge into the dominant Anglo-Saxon culture.

The rise of anti-Semitism and Fascism in the 1930s meant that assimilation became hard to sustain and a policy of cultural pluralism was adopted. It was argued that the melting pot idea was anti-democratic and that cultural diversity and a respect for ethnic and racial differences strengthened America.

During World War II Black people challenged discrimination in the military services and in the workforce. This prompted policies to end discrimination based on race, creed, colour, or national origin in the employment of workers in the defence industries and governmental agencies. By the end of the Second World War, it had become difficult to legitimately espouse assumptions about unequal racial differences. Apart from changes in scientific thinking, the opposition to Nazism shaped the refutation of racism as legitimate. There was a growing sensitivity to racism in the aftermath of the holocaust and the US Government began to respond to anti-racist resistance at home (West, 2006).

The first official civil rights agency, the Inter-Racial Commission, was set up in 1943. A major focus was to study the problems of discrimination particularly within the field of human relationships. This led to the development of the first sensitivity training to address inter-racial tensions (Lasch-Quinn, 2001).

Sensitivity training

The first sensitivity training group or T-group was developed by social psychologist Kurt Lewin in 1946, following a request by the Inter-Racial Commission for his assistance in combating racial and religious prejudice. Lewin conducted an experimental workshop that trained people for community action against prejudice and examined what changed the attitudes of the trainees.

The goals for trainers included:

- ❖ developing interpersonal skills
- ❖ exploring the source of prejudice
- ❖ learning how to alter attitudes
- ❖ developing an understanding of their own attitudes and values.

The results six months later showed positive outcomes in terms of improvement in group relations, increased sensitivity and better performance in moving from good intentions to actual behaviour. These outcomes led to the establishment of the National Training Laboratories in 1947, devoted to sensitivity or group dynamics training.

Sensitivity training gained momentum in the 1960s. The Civil Rights Act of 1964 outlawed discrimination based on race, colour, religion, sex or national origin. The Act prohibited discrimination in public facilities, in government, and in employment, and made financial provisions for race equality

training (Coffey, 1987). Sensitivity training workshops on race relations expanded and were conducted in schools, police departments, social services agencies, community organisations and the business world.

The growth of the field of psychotherapy further influenced the framework of sensitivity training. Like dynamic psychology it stressed bringing into consciousness deep feelings. It attempted to resolve conflict through confrontational methods and drew on behavioural methods like role-play. The main assumptions were that individuals needed to unearth and confront their deepest feelings and that this could be done in a very compressed amount of time.

The notion that racism could be explained in psychological terms and addressed with sensitivity training approaches was popularised by psychiatrist Price Cobb. He suggested that a kind of radical therapy of race relations was what was needed to address racism (Grier & Cobb, 1968). Cobbs co-facilitated the first encounter group in 1967 on 'racial confrontation as transcendental experience'.

Cobb proposed a clinical model that he claimed could transform racial attitudes, a technique he called ethno-therapy, which treated the disease of racism. Confrontation was seen as necessary for changing attitudes. The technique entailed instant intimacy, intense emotional expression, and the stripping of one's defences. This would permit total disclosure of the misguided feelings and attitudes regarding race. These could then be analysed and the misinformation underlying them examined.

The premise of the approach was that small group confrontation guided by trained leaders would raise participant's awareness of the role of racism. Positive change in race relations was primarily a matter of technique (Lasch-Quinn, 2001).

While racism was seen as the cause of inequality and inter-racial tensions, the problem of racism was located firmly within the individual psyche. This approach has been criticised for focusing more on individual growth and sensory exploration rather than on social action to fight racism. Lasch-Quinn (2001) suggests that the replacement of arguments for equality and social justice with ones based on psychological concepts altered not only the means by which change could be seen to come about but also the ends themselves. The desired goal was no longer equality and participation but individual psychic wellbeing. This psychological state was much more nebulous, open to interpretation, difficult to achieve and more controversial than the universal guarantees of political equality.

Sensitivity training's emphasis on confrontation soon made it unpopular with most federal agencies. During the 1970s the focus moved to developing training that addressed the requirements of the law. Many race related training programmes shifted in focus from changing attitudes to changing behaviour as the law required (Coffey, 1987).

Although the emphasis changed to the use of the law to address racial inequality, some race related training continued to be influenced by the sensitivity training framework emphasising the need to change individual attitudes. 'White awareness training' is one example (Katz, 1978). Katz argued that racism was a pathological disease and the overall objective of training was "to help whites become aware of how racism affects their lives and help them change their attitudes and behaviours". The best way to achieve this was through confrontation and re-education. But the unpopularity of confrontational models of training meant that this approach was not widely adopted in the United States.

Affirmative action

Affirmative action was introduced during the 1970s, requiring the use of racial quotas to address inequality. As a result of this, a range of race equality training approaches emerged, some behaviourally orientated, others focusing on attitudes and feelings. The requirement of federal government for non-discriminatory practice led to more agencies developing training that emphasised behavioural outcomes rather than attitude change. The design of training programmes began to be based more on an assessment of organisational needs in relation to government requirements and was linked to a wider programme of organisational development. Courses were more information-based, covering the law and 'Black history'.

From the late 1980s affirmative action became increasingly unpopular politically. Moreover, despite affirmative action, there had been a vast increase in discrimination complaints and lawsuits during the 1970s and 80s (Lasch-Quinn, 2001). The concept of diversity was adopted as a means of addressing inequalities of all kinds.

Diversity management in the workplace

Diversity management within the workplace was seen as a way of changing organisational culture in order to remove previous practices that may have created inequality. The suggestion was that changing organisational culture through valuing diversity would add value to the organisation.

Although different schools of thought emerged including valuing diversity and managing diversity, such training was increasingly deemed a necessity in order to change organisational culture and attitudes.

The content of diversity training varied but the emphasis was on the need to develop cross-cultural awareness through increased knowledge of different cultures. However, there is evidence that diversity training continues to be influenced by the sensitivity training approach with a focus on confrontation and individual attitude change.

Diversity management was seen as a more acceptable affirmative action and diversity training a more palatable alternative to the previous sensitivity-style training. However, diversity reifies difference and rests on the assumption of shared experiences within groups. The ideal of diversity is that bringing individuals of diverse background together will transform the negative attitudes of the formerly exclusive group. It is assumed that diversity in the workplace will breed tolerance and respect, improve the pool of skills and enhance productivity (Wood, 2003).

While diversity celebrates difference through the development of cultural knowledge, the structural sources of inequality and discrimination are left unchanged. This approach reflects the ongoing retreat within race relation policies from the original civil rights goals of racial justice and equality (Adelman, 2004).

The concept of cultural competence

The concept of cultural competence developed within the diversity management framework and was applied extensively within health and social care systems. According to Fitzgerald (2000) the term cultural competency in relation to health professionals first appeared in an American Psychological Society position paper by Sue *et al.* (1982). It is suggested that the term came into use for two reasons. Firstly, it was in keeping with the trend towards 'workplace competencies' and provided a conceptual framework that was consistent with thinking about good professional practice. Secondly, there were

problems with the concept of ‘cultural sensitivity’ and ‘cultural relevance’, which had informed the frameworks for previous training.

Although a number of models of cultural competence have developed over the last two decades, the most commonly used definition and conceptual framework is based on the work of Cross *et al.* (1989). In it, cultural competence is defined as:

“A set of congruent behaviours, 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)

At the operational level cultural competence is the ability to integrate knowledge about individuals and groups into specific standards, policies, practices and attitudes, which are used to improve the quality of health care and ultimately produce better outcomes (Davis, 1997). Cross *et al.*'s (1989) model identifies a continuum of cultural competence from cultural destructiveness through cultural incapacity, cultural blindness and cultural pre-competence and cultural competency to cultural proficiency.

Race equality training in the UK

The development of race equality training in the UK has followed a historical pattern very similar to that of the United States. After the Second World War there was a significant increase in the demand for labour to reconstruct Britain. The Commonwealth states within the former colonial territories provided a ready source of labour for recruitment. The British government introduced a deliberate policy of encouraging immigration from these Commonwealth countries to solve labour shortages. The Nationality Act, 1948, gave Commonwealth citizens special immigration status enabling them to freely enter and settle in Britain with their families. Immigrants from regions such as the Caribbean, India, Pakistan and Africa provided the low-skilled and unskilled labour needed to build post-war Britain.

It was expected that these immigrant communities would soon assimilate into the host society. However, this was not to be the case, and these communities soon realised that they were not welcomed and, in fact, were discriminated against in all aspects of society. Increasing social tensions culminated in ‘race riots’, such as that in Notting Hill in 1958, when Black people were attacked. The rise in racial tensions led to the end of active recruitment of labour from Commonwealth countries and legislation to limit immigration (Commonwealth Immigration Act, 1962) and to outlaw direct and overt racism (Race Relations Act, 1965). The Government’s two-pronged approach was presented as a means of facilitating the integration of Black communities in British society.

This approach enabled the development of a new philosophy of cultural pluralism, which replaced the policy of assimilation. It was acknowledged that immigrant cultures would to some degree persist in Britain and were to be accepted. This went against the concept of assimilation or the ‘melting pot’, where all cultures dissolve and merge into each other, and required a new policy response from public services. Service providers needed to be aware of immigrant cultures and the special needs resulting from their cultural differences. Thus race related training in Britain developed as part of a wider response to address racial tensions and discrimination.

Multicultural training

Multicultural training or ‘learning about them’ provided the dominant training assumption throughout the 1960s and 1970s (Luthra & Oakley, 1991). The strategy in multicultural training is primarily the provision of information on ethnic minority cultures. The underlying assumption was that the problem to be addressed was mainly one of ignorance by the host community of minority cultures, and the provision of information would itself lead to changes in attitude and behaviour. Thus race inequality was caused by cultural differences and the inability of Black immigrants to become sufficiently integrated and not by racial discrimination.

From the late 1970s training that focused on providing cultural information began to be questioned. Multiculturalism and pluralism were attacked as they were seen to mask the reality of racism and discrimination, and do little to address the issues of social justice and equality (Luthra & Oakley, 1991).

Equal opportunities

The Race Relations Act (1976) established the unlawfulness of indirect racism and a duty was placed on local authorities to ensure the elimination of unlawful racial discrimination and promote equality of opportunities between different racial groups. For the first time, addressing race equality was seen to be an organisational rather than an individual responsibility.

Although race related training was not a requirement under the legislation, the Commission for Racial Equality (CRE) published guidelines on training and provided advice on good practice. The main emphasis of training was on equal opportunities in employment.

There was subsequently an increased demand for training aimed at promoting equal opportunities and reducing discrimination. Training typically comprised information provision about race inequalities and the ‘psychology of prejudice’. The development of ‘race equality units’ in many local authorities led to a growing emphasis on staff training as a means of implementing race equality policies in both employment and service provision (Luthra & Oakley, 1991).

The development of race equality training was given a further impetus after the 1981 riots in Brixton, by the recommendation of the Scarman report for race equality training to improve policing (1981). The Scarman report denied that social unrest was the result of institutional racism but cited ethnic disadvantage as the main cause. Specific programmes were recommended as a means of addressing ethnic disadvantage. The focus shifted to meeting the cultural or ethnic need of minority groups. Culturalism or ethnicism as policy was now seen as the answer to racial inequalities (Sivanandan, 2005).

As more organisations developed policy commitments to tackle racism, the demand for training and trainers increased. There was no central strategy to promote and staff race equality training, thus a range of *ad hoc* responses by a cadre of entrepreneurial trainers emerged. These used a range of different approaches with different premises and different aims and emphases (Luthra & Oakley, 1991).

While racial inequality was explained within a culturalist framework, training developments within the public sector reflected a diminished emphasis on minority cultures. Many training programmes began to adopt the US-style Racism Awareness Training (RAT) approach. According to Brown & Lawton (1992), course titles picked up the terms ‘race awareness’, ‘racism awareness’ and ‘racial awareness’ with no consistency, and at the height of popularity it was attached to any kind of training in the field of race.

A considerable amount of criticism of racism awareness training emerged by the mid-1980s. Sivanandan (1985) and Gurnah (1984) argued that the individual-centred approach diverts attention away from organisational, institutional and structural issues and from real anti-racist action. In response to these criticisms, some organisations incorporated elements of RAT into anti-racism courses with the aim of providing training that focused on change at both the individual and organisational level.

Although anti-racism approaches were criticised as ‘loony leftism’ and political correctness, British social policy continued to emphasise cultural differences and promote multiculturalism as a means of addressing racial inequality.

The late 1980s and early 1990s saw a shift in emphasis by the Commission for Racial Equality (CRE) and the Equal Opportunities Commission away from demands for social justice and tougher legislation to collaboration with government and business to achieve change through employment policies (Davis *et al.*, 2003). This was in keeping with the Conservative government policy, which preferred a business-led response to disadvantage rather than a state-led one.

This led to the emergence of a broader training approach to encompass gender and disability as well as race inequality, under the banner of equal opportunities. Training activities were classified as equalities or equal opportunities with three sub-groups: equalities with broader issues of positive action, gender and disability; equalities anti-racism; and equalities diversity training (ILO/UN, 1999).

Managing diversity in the UK

During the 1990s the concept of ‘managing diversity’ developed in the business world in the United States and was adopted in the UK. This has increased rapidly with one-third of 200 top British companies actively involved in diversity management in 2000 (Collet & Cook, 2000) and 70% of all organisations having diversity management policies in place by 2005 (Mizra, 2005).

A 2002 review of race related training within local authorities and the NHS found that the trend in race equality training in the UK was towards diversity (Tamkin *et al.*, 2002). They argued that race issues had been subsumed into a broader agenda which had moved from an emphasis on reducing difference through equal opportunities to a diversity approach with an explicit recognition of difference. It was further suggested that the term ‘diversity’ was considered more inclusive than race alone, and was a less emotive way to approach race and a more modern term than ‘equalities’.

Cultural competence and capability

While equalities and diversity management are currently the overarching frameworks for addressing race inequalities in the UK, there has been some interest in adopting the US-style cultural competence model to address inequalities in health care (Papadopoulos *et al.*, 2003; Webb & Sergison, 2003; DH, 2003).

Cultural competency is the accepted approach within the Government’s action plan (DH, 2005) to address race inequality in mental health services.

Cultural competence has developed out of the diversity framework, which explains racial inequality as a problem of cultural differences. The policy and training approach focuses on valuing or managing cultural difference paying little attention to individual and institutional racism as a cause of racial inequality.

The concept of cultural capability has also recently emerged. Bhui (2002) suggests that it is important to emphasise practitioner capabilities and not just their competence to perform certain roles. The concept is further developed in the publication, *Inside Outside* (NIMHE, 2003), where it is proposed that it is essential to improve the cultural competency and capacity of the workforce in order to reduce racial inequalities. Cultural capability is proposed to consist of two elements: training in cultural competency and ensuring that there is a multicultural workforce.

Cultural capability is therefore a framework for service delivery rather than a model or an approach to training.

Current models of race equality training in the UK

Our historical analysis of race equality training suggests that six major models of training have emerged in the UK since the 1960s: multicultural, racism awareness, anti-racism, equalities, diversity and cultural competence or cultural capability. The development of these models has been influenced by a number of factors including definitions of race and racism, and legislation and social policy on race inequality. The following descriptions summarise each model as it is applied today.

❖ Multicultural training

Multicultural training focuses primarily on the provision of cultural knowledge. Trainees are introduced to different ‘cultural’ foods and habits. More recently the multicultural model of training has broadened to include differing religious practices.

Courses sometimes include elements on race relations such as factual information about the extent of racial discrimination and psychological theories of prejudice and racism. The approach is primarily didactic with little attempt to apply learning to practical situations.

Other approaches to training within this framework include cultural information, cultural awareness and cultural sensitivity training.

❖ Racism awareness training

Racism awareness training (RAT) is based on the principles and method of the ‘white awareness’ programme, developed in the US by Judy Katz in 1978. The premise of this approach is that racism is a psychological disorder suffered by white people. This disorder, racism, is embedded from an early age at both a conscious and an unconscious level. The overall objective of the programme is to help whites change their racist attitudes and behaviours.

The training uses confrontational methods to enable the individual to acknowledge their own racism and to resolve this pathology. The course consists mainly of pair and group exercises staffed by one or two facilitators who are expected to have a deep understanding of racism (Brown & Lawton, 1991).

The original intention was that training was a six-stage process conducted over several days. Based on the goals of the training programme set out by Katz, the content of training includes: the definition of concepts of bias, prejudice and racism; examination of individual, institutional and cultural racism; exploration of personal feelings and fears around racism; identification of own racist attitudes and behaviours; and developing and implementing strategies to combat institutional and individual racism.

❖ Anti-racism training

This model is a modification of RAT, which maintains a strong emphasis on addressing racism directly, but also includes more organisationally orientated elements. Anti-racism training thus addresses both personal and organisational goals. Racism is seen as endemic in society and in the culture of institutions and cannot simply be reduced to individual attitudes. The overall aim is to challenge and eliminate racism.

Training methods include didactic and confrontational techniques, within a collaborative rather than judgemental framework (Luthra & Oakley, 1991). Course content includes exercises to develop awareness and job performance. While the focus is on changing behaviour, attitude change is seen as a prerequisite.

❖ Equalities training

The legitimacy of equalities training is based on the fact that racial discrimination is illegal. Employers and service providers therefore have a legal obligation to prevent discrimination whether in intent or effect. The focus is on the recognition of racial inequality and action to identify and prevent it, not necessarily on the causes or extent of racial discrimination.

Equalities training may be part of a wider programme that addresses equal opportunities in relation to other forms of discrimination such as gender, disability and sexual orientation. Courses generally have an element that focuses on explanations of rules, legal obligations and formal duties, and an element that attempts to dispel misinformed beliefs and assumptions with the aim of encouraging an understanding of the impact of racism and discrimination on job performance.

Training methods are aimed at establishing ownership of the possibility of discrimination and the need to address it and at devising a strategy to deal with it. Luthra & Oakley (1991) describe three stages in the delivery of training:

1. Selling the idea to managers and policy makers.
2. Didactic methods to provide technical information and facilitate planning exercises.
3. Technical instructions and skills development.

Equalities training seeks to produce change in behaviour and specifically avoids addressing people's own attitudes to race.

❖ Diversity training

Motivations behind diversity training include compliance with legislation, fear of litigation, social justice, desire to expand into diverse markets, and overall organisational transformation. However there is a lack of consensus on the meaning of diversity training. To some, the focus is narrowly on those categories protected by law, primarily race, gender, and disability (e.g. Day, 1995). Others argue for a broadly inclusive definition that encompasses age, educational level, family structure, job function, sexual orientation, ethnicity, and values, among others (Pegg, 1997). This broader approach focuses on understanding and valuing the differing perspectives and approaches that people of all types of backgrounds bring to work.

There is a range of approaches within the diversity framework which includes intercultural and diversity management training (DeRosa, 2001).

a) Intercultural approach

The intercultural approach focuses on the development of cross-cultural understanding and communication between people of different cultural groups. It tries to help people develop sensitivity to the cultural roots of one's own behaviour, as well as an awareness of the richness and variety of values and assumptions of peoples of other cultures. In this approach, ignorance, cultural misunderstanding, and value clashes are seen as the problem, and increased cultural awareness, knowledge, and tolerance are the solution. Cultural identity and ethnicity are the focus, while racial identity is not often examined. Gender and sexual orientation are explored within the context of culture and tradition, but not within the framework of power and oppression.

b) Managing diversity

The emphasis in this approach is awareness and appreciation of the contributions of different cultures. The main aim is to promote diversity in the workforce to improve productivity, efficiency and achieve best value. Managing diversity is an extension of the business case for equal opportunities. It includes all ways in which people differ, not just race, gender and disability. Training usually targets the managers of an organisation. While some experiential activities may be included, examination of personal attitudes and behaviour are likely to be limited to the business context. Workshops often focus on how stereotypes and prejudice affect hiring and promotional decisions, and undermine team effectiveness, productivity and, ultimately, profitability.

Lasch-Quinn (2001) suggests that common themes in diversity training materials include:

- ❖ The view that negative stereotypes are the cause of tensions regarding racial or cultural differences.
- ❖ The need to overcome stereotypes through intervention along therapeutic or behaviourist lines.
- ❖ The aim of replacing negative stereotypes with understanding of group attributes and to replace old behaviours with new ones based on more enlightened ways of thinking about difference.

The most common purpose of diversity training is to raise awareness and understanding of cultural differences, and to change the behaviour of individuals, in order to eliminate discrimination. It also aims to change individuals' attitudes and organisational cultures.

Training courses generally start with an inclusive definition of diversity and clear objectives that are linked with organisational goals. Employees are often involved in their design and top-level support from senior management is usually evident. Training includes awareness (examining assumptions, biases and stereotypes) and skill development (listening, communication and conflict resolution). Diversity trainers tend to use readily available materials, such as films and handbooks, that are appropriate for use in short workshops. Little emphasis is given to the fact that there is an extensive range of literature in this area with different views and perspectives on racial inequality. Resistance is confronted by providing facts, appealing to deep values, and identifying human commonalities while recognising the great variation in their expression. Overall, the focus is on finding ways for people to work co-operatively despite differing perspectives.

❖ Cultural competence training

Although a number of models of cultural competence have developed over the last two decades, the most commonly used definition and conceptual framework is based on the work of Cross *et al.* (1989).

Cultural competence is not regarded as a purely clinical model as it addresses cultural intervention at the individual, organisational and policy levels. At the clinical level, it is defined as the acquisition of competence in three main areas: beliefs and attitudes, knowledge and skills. At the individual level, cultural competence is viewed as a life-long process, which requires practitioners to examine their own attitudes and values, and acquire knowledge and appreciation of cultural differences and similarities within, among and between groups (NCCC, 2004).

It is argued that cultural competence should be incorporated into all aspects of policy making, administration, practice, and service delivery and should be informed through the involvement of service users, key stakeholders and communities.

Cultural competence is considered a behavioural approach, which does not focus on implicit levels of racism but operates on the principle that changes in attitudes can be implied through behavioural change.

Cultural competence training describes a vast array of educational activities aimed at enhancing the capacity of service delivery systems to meet the needs of different racial and ethnic populations. Training can include educational activities that aim to: increase cultural awareness and sensitivity; provide demographic information on local populations; build skills in bicultural and bilingual interviewing and assessment; and increase cultural knowledge and understanding.

Summary

These models are summarised in Table 2. It is clear that there have been some shifts in the approaches to race equality training ranging from basic information sharing to challenging institutional practices, but the approach that seems to prevail is to focus on cultural difference rather than the more challenging concepts of racism, discrimination and oppression. Moreover, there is little evidence to show to what extent race related training has an impact on improving outcomes for BME communities.

Table 2: Different models of race equality training in the UK

MODELS	Assumptions/ premise	Aims of training	Target group	Expected outcomes	Variants
Multi-cultural	There is a lack of awareness of different cultures and the extent of racial discrimination.	Provide information on different cultures, and racial discrimination.	Individuals	Better informed individuals Behaviour change	Cultural awareness Cultural sensitivity Information
Racism awareness	All white people are racist and must be made aware of and acknowledge their racism to achieve change.	To help whites to become self-aware of how racism affects their lives.	Individuals	Change in attitudes and behaviour.	
Anti-racism	Racism and discrimination are endemic in organisations and people must be taught how to combat them with organisational support.	Provide information Develop self-awareness and job performance.	Individuals and organisations	Target is behavioural change but change of attitude is a necessary condition.	
Equalities	It is illegal to discriminate; agencies and professionals must uphold the law. The extent and cause of discrimination is not so important.	Establish ownership of the possibility of discrimination and design and implement a strategy to deal with it.	Individuals and organisations	Strictly behaviour change. Avoids tackling racist attitudes.	Anti-discrimination Equal opportunities
Diversity	Culture of an organisation leads to inequality. Valuing diversity will reduce inequality and improve productivity. More palatable than a focus on race.	Awareness and appreciation of the contributions of different cultures. Culture change at the organisational level.	Individuals and organisations	Behaviour change	Managing diversity Valuing diversity Intercultural Cultural diversity
Cultural competence	Health care systems and providers need to respond to an ethnically and linguistically diverse population to reduce racial/ethnic disparities.	Increasing cultural awareness and sensitivity. Providing bicultural / bilingual skills.	Individuals, organisations and policy.	Behaviour change	

Adapted from Luthra and Oakley (1991)

3

Delivering race equality training

Introduction

This chapter discusses the key elements in the process of delivering race equality training. The findings presented are based primarily on data from the training commissioners' questionnaires. Responses were received from training commissioners representing 45% (47) of all mental health services in England (34 from the statutory sector and 13 from the independent sector).

Relevant data from the employees' (461 respondents) and training providers' (35 respondents) questionnaires are included as necessary.

It should be noted that in some cases the distribution of responses in the different categories does not add up to 100%. This occurs when more than one category was selected by the respondents.

Attendance

The majority (67%) of employees reported that they had attended race equality training in the last three years. The main reasons given for not attending training were that the organisation did not offer any training in this area (39%) and a lack of awareness of any training (25%). Other reasons included: lack of time due to workload and other commitments (11%), too much mandatory training, and race related training was not a priority (4%).

Some individual comments indicated that there was a lack of funding, a lack of personal interest in the topic, a lack of relevance to the work they do or that there was no need to be trained in race equality as they belonged to a minority community.

Organisational policy on race equality

The impetus for organisational change in relation to discrimination and inequalities is generally based on either the legal case, when it is argued that organisations are required to address race equality because the law says they must do so, the moral or ethical argument that focuses on the need to be fair and non-discriminatory or the business case of the inefficiency of discrimination.

The legal case has been set out by the Race Relations Act (1976) and the Race Relations (Amendment) Act 2000 which require public authorities to eliminate racial discrimination, and to promote equality of opportunities and good race relations. Organisations are required to prepare and publish a Race Equality Scheme (RES) to this effect. The Delivering Race Equality (DRE) Action Plan (2005) emphasises the legal case but also draws on the business and moral cases for promoting and delivering race equality. DRE therefore requires all mental health organisations to have a race and cultural capability framework as well as an updated RES.

The majority (96%) of the organisations we surveyed reported having a formal policy on race equality. However, a recent audit by the Healthcare Commission (March 2006) has found that only 60% of NHS trusts have published a RES and only 1% (7 out of 570) have fully met the Race Relations (Amendment) Act's requirements.

Furthermore, although the majority (81%) of mental health service employees surveyed reported that they were aware of the existence of a RES in their organisation only around one-third (32%) said they were very familiar with the scheme. Managers and human resource (HR) personnel tended to be more familiar with the RES than frontline staff.

A relatively small number of employees within both the statutory sector (22%) and the independent sector (25%) reported that they felt involved in the development or implementation of the RES.

Leadership and commitment

The initial thinking behind the conceptual framework of DRE was set out by the then Secretary of State for Health and the Chair of the Commission for Racial Equality (CRE) (Reid & Phillips, 2004). They argued that systemic bias accounted for 99% of racial inequality in the NHS. This bias is seen as the result of insufficient leadership focused on effecting change. DRE thus requires that organisational race equality and cultural capability frameworks and plans should be managed at a senior level and that chief executives are to be directly accountable for progress.

Our survey showed that leadership on race equality issues within mental health services was the responsibility of the HR department (44%), senior managers (42%) and chief executives (28%).

58% of training commissioners reported that race equality was given fairly high priority in their organisations but less than half (47%) felt there was a high level of commitment.

When asked to describe their personal commitment, one training commissioner commented:

“In response to the delivery of race equality in mental health, and as a participating organisation for a pilot Focused Implementation Site [of the Government's DRE strategy], race equality training is a high priority for the trust. As the person with the lead responsibility for equality and diversity, I will personally ensure that it is on the service and department agenda.”

(Director, Statutory Sector, North West)

Some individuals indicated that they were highly committed at a personal level but were concerned about the challenges in ensuring proper commitment within the organisation, especially where the local population had a low percentage of BME communities.

“Small BME numbers in population make it even more important to raise awareness – but can equally make it challenging to get appropriate organisational time devoted to the topic.”

(Director of Corporate Development, Statutory Sector, North West)

“The perception of the staff is that it is not needed as there is a low percentage of BME groups in the area. Thus the training is poorly attended, particularly when there are operational requirements to cover shifts.”

(Learning and Development Manager, Statutory Sector, North East/Yorkshire)

Race equality training provision

The majority (91%) of organisations reported that race equality training was provided for employees and 86% of those said training was provided for all staff. Three organisations were planning to provide training in the next six months and one organisation plans to do so within the next 12 months.

Training was reported to be compulsory for all staff in 53% of cases, while 28% strongly encouraged staff to attend and 5% said that attendance was voluntary.

Of the organisations providing race equality training, the majority (67%) had been doing so for between two and five years, 25% for less than one year and one organisation, in London, said that they had been providing training for more than ten years.

The types of training provided included: diversity (86%), cultural awareness (51%), cultural sensitivity (44%), racism awareness (35%) and anti-racism (12%).

Training commissioners reported difficulty in quantifying the cost of training per employee. Those who provided in-house training said that they had not calculated this. Some organisations said that cost was dependent on the content of the course. The costs reported ranged from £10 to £150 per employee, which does not include staff replacement costs.

Decision to provide training

Previous studies have shown that the major drivers for race related training were race relations legislation, government policy, and reaction to events such as the Stephen Lawrence Inquiry (e.g. Tamkin *et al.*, 2002). Staff and service users were much less likely to be motivators for training.

Our survey found that similar factors had influenced the provision of race equality training in mental health services. The vast majority (84%) of organisations reported that the Race Relations (Amendment) Act and government policies, including the DRE Action Plan and the David Bennett Inquiry Report (79%) were the most influential factors in the decision to provide race equality training.

Only a small number said that pressure from service users and community groups (19%) or from staff (16%) was a deciding factor in providing training.

Table 3 summarises the factors that influenced decisions to provide race equality training.

Table 3: Factors influencing decisions to provide training

Race Relations (Amendment) Act	84%
Government policies (DRE Action Plan and the David Bennett Inquiry Report)	79%
Development of a local diversity strategy	79%
Training needs analysis	49%
Legal vulnerability	42%
Pressure from service users and community	19%
Pressure from staff	16%
Internal race equality audit results	16%
Local implementation team assessment	14%

The following comments reflect race equality training providers' views on the factors that most influenced an organisation's decision to provide race equality training:

“Race equality training is commissioned mainly to meet legal and policy requirements.”

“Training is not generally commissioned to meet specific organisational needs.”

“Training is rarely commissioned specifically to address inequalities in service delivery or to improve practitioner skills.”

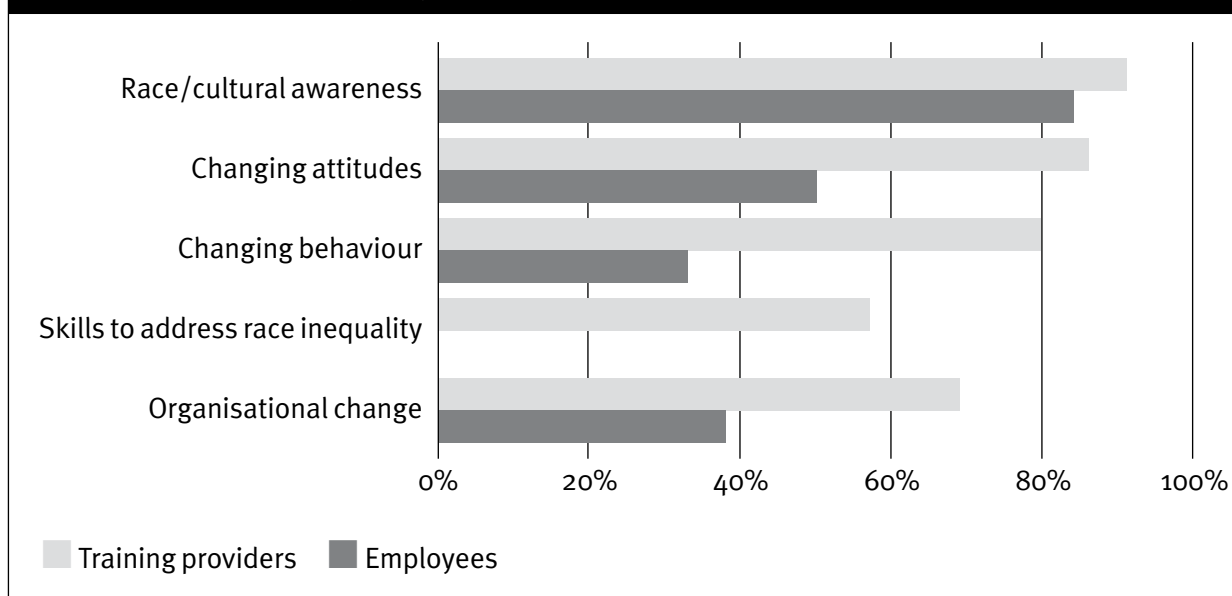
“Organisations are keen to be seen to be doing the right thing, meeting legal requirements and ‘ticking the boxes’.”

Aims and objectives of training

Previous studies of race related training (e.g. Tamkin *et al.*, 2002) found that the most important objectives of training in the public sector were raising awareness and understanding of cultural differences and changing behaviour. Other popular objectives were improving customer service, attitude change at the individual level and cultural change at the organisational level.

The majority of mental health service employees (84%) and race equality training providers (91%) responding to this survey reported that one of the main aims of training was to increase awareness of race and cultural issues. There was less agreement on other key aims of training. Employees felt training focused more on changing attitude (50%) than changing behaviour (33%), while the vast majority of training providers (86%) felt training gave high priority to changing both attitudes and behaviour (80%). Over half of training providers (57%) felt training provided specific skills to address race inequality. However, none of the employees felt this was a main aim of training. Although the majority of training providers (69%) felt training addressed organisational change, only 38% of employees felt this was an aim of the training they had received (Figure 1).

Figure 1: Aims of race equality training



Brown and Lawton (1991) suggest that race equality training does not refer to a single type of training but embraces a wide range of activities, which reflect a real diversity of needs and training aims. Differences are influenced by factors such as the nature of the organisation, the direction of pressure for change and the sector. They suggest that training needs and aims should be determined by an assessment of the current weaknesses in the organisation’s ability to promote equality and the changes that are necessary to improve them.

Content of training

Due to the lack of standards, definitions and national guidance on race related training the content of training tends to vary widely. Content seems to be influenced by the individual trainer’s perspectives on issues of race, culture, ethnicity and the nature of inequality, and by the demands of the commissioning organisation.

The Commission for Racial Equality (CRE) has issued guidance on training within the context of the Race Relations (Amendment) Act (CRE, 2006). The guidance recommends that staff are required to have the skills and knowledge to help to eliminate racial discrimination and promote equal opportunities and good race relations. It is recognised that generic ‘race’ or ‘diversity’ training can be a valuable contributor to meeting the training duty, but on its own is unlikely to comply fully with the duty. The guidance recommends that training should enable all staff to:

- ❖ understand the race equality duty;
- ❖ understand how the race equality duty will apply to their areas of work;
- ❖ be clear what actions they need to take to meet the duties;
- ❖ understand the race equality outcomes or goals towards which the public authority is working.

Peppard (1980) argues that the practical objective of race related training should be to enable staff to carry out their duties with equity and efficiency. She suggested that the content of training should include a common core of historical, psychological, legal and cultural background information,

combined with other subjects tailored to the particular occupational group. In addition, training should address issues of institutional racism and challenge attitudes and belief within the context of professional practice (cited in Brown & Lawton, 1991).

The International Labour Organisation (ILO) evaluation of anti-discriminatory training in the UK identified some common themes in training. These included coverage of legal requirements, information about levels of discrimination and disadvantage, and skills for anti-discriminatory practice (ILO/UN, 1999).

A comprehensive review of race and diversity training provided to police officers in England and Wales found a wide variation in training content but with some broad themes covering historical factors and behavioural theories, definitions of institutional racism and discrimination, specific aspects of service delivery (i.e. hate crime investigation), and in places a few links to other aspects of diversity (HMIC, 2003).

The main content of race equality training identified by employees in our survey included policy and legal issues (88%), and understanding and respecting difference (82%). A smaller number of respondents cited elements that addressed the practical aspects of delivering race equality. Table 4 shows the content of race equality training courses.

Table 4: Content of race equality training courses	
	Employees
Policy and legal issues	88%
Understanding and respecting difference	82%
Challenging stereotypes and prejudice	78%
Definitions of racism and discrimination	77%
Information on culture and religion	67%
Discussing different forms of racism	66%
Exploring experience of racism	65%
Recognising unconscious racism	64%
Skills for delivering non-discriminatory practice	60%
Learning appropriate behaviour	53%
Developing plans for race equality in practice	51%
Strategies for resolving race related conflict	39%

Length of training

Previous studies have found that race related training was generally delivered as a one-off event. Very few courses were part of a coherent programme of events. The length of training ranged from a half-day upwards to a week, with the trend towards shorter training courses. Training is usually delivered in small groups of around 8-15 participants with two trainers facilitating.

Tamkin *et al.* (2002) found that almost half of race related training courses were standalone, addressing issues of race. Others were embedded in equality and diversity, induction or management training. All staff groups were targeted for training often starting with management and human resources personnel. It is suggested that this may indicate that training moves through the organisation in waves starting with those who have the greatest responsibility for leading on race and diversity issues.

In our survey, just under one-third of the employees (30%) received specific standalone training in race equality. Of those who received standalone training, more than half (51%) had attended a training event of 1-2 days, and 32% had attended half-day events. A small number (seven) said that they had attended a five-day training course.

More than half (52%) had attended training that was part of other equality courses. Others had attended training as part of induction and management training, pre-registration/qualifying training and even within courses for lifting and handling.

Training delivery methods

Brown and Lawton's review covering the 1980s (Brown & Lawton, 1991) found that training emphasised the value of group work and self-discovery. Workshops and discussions were used extensively. Many trainers used video films to trigger discussions which were reported to be valued by managers who felt this had a profound effect on the trainee's personal understanding of prejudice and discrimination. There was early evidence of the use of distance learning packages particularly in the finance sector.

The more recent review by Tamkin and colleagues (2002) found that the most common techniques used to deliver training were verbal and written information and group discussion. A smaller number used TV, video, role-play or team building exercises.

Our survey indicated that approaches to training delivery mainly included verbal methods (93%), group discussion (89%), written information (79%), and sharing and discussing personal experiences (63%). 40% of those who had attended training found group discussion most effective, while only 13% found sharing and discussing personal experiences useful.

Effectiveness of race equality training

There are very few studies that have evaluated the effectiveness of race related training in the UK. The only comprehensive evaluation of race relations training, for the Metropolitan Police, (Tamkin *et al.*, 2003) showed that the reaction of about half of the trainees was that training had little relevance or had little impact as 'they knew it already'. Learning was primarily around gaining a better understanding of cultural issues and minor changes were reported in terms of individual behaviour. There was a perception that there were some positive changes in the culture within the police force and in community relations.

A systematic review to synthesise the findings of studies evaluating interventions to improve the cultural competence of health professionals concluded that cultural competence training shows promise as a strategy for improving the knowledge, attitudes, and skills of health professionals. However, evidence that it improves equity of services across racial and ethnic groups is lacking (Beach *et al.*, 2005).

Most of the employee respondents to our survey were very satisfied or fairly satisfied with the quality of trainers delivering training (78%), the length of the training (70%), the mix of participants (69%), and the aims and objectives of the training (76%). There was less satisfaction with the support received after the training event (30%).

Some comments on the quality of training:

“Training was not delivered by someone who had an understanding of our mental health services and population. [The trainer] used a 1950s video of a USA classroom, which was abusive to children. Training was not contextualised. Very blasé trainer – no expectations were given as to Trust standards.”

“Training was based on experiences of the group which was 100% white and had very little to offer.”

“Some participants used the forum to air their own xenophobic and racist issues and then portrayed themselves as victims as opposed to perpetrators. This was not challenged by the facilitators.”

The majority of participants (77%) reported that there was some positive impact on their work and on them personally.

“Racial awareness and competency had not been offered before and my experience was positive as it consolidated my knowledge base, developed my understanding of potential issues and challenged my professional mind set. The only deficit I felt was that the training specifically addressed Black/Asian racial issues and not racial issues that involve the whole of minority groups.”

“The case studies and opinions expressed have made me think and reflect on people’s behaviours in a broader sense, recognise issues which in the past I may have been blind to, and be sensitive to colleagues’ and clients’ needs which I may have overlooked in the past.”

Others said that the training challenged their attitudes and made them rethink some of their assumptions.

“It was helpful to consider how issues are currently handled and in particular our personal responsibilities and what could be improved.”

According to another respondent, the training:

“...made me question my decision-making processes and think from a more objective viewpoint. [It] made me question my own views and opinions.”

Less than half of the participants (48%) felt that training had a positive impact on the organisation or service delivery.

“...practitioners are still largely colour blind or unaware of importance of minority ethnic issues and needs.”

“It felt like the organisation was addressing the issue because it had to be seen to do so.”

The following comments suggest the need for more emphasis on issues of service delivery:

“[The training] reinforced the importance of equality and diversity issues, of which I was already quite well aware and underscored the importance of the organisation. But the stand was more towards protection of the organisation (e.g., from litigation) than towards the experiences of those subject to discriminatory and oppressive practices.”

- “...concentrated more on legal/policy issues than on how new learning can help in working with clients and responding more appropriately in practice.”
- “...good enough as awareness training but [it] should be specifically focused within teams, raising awareness, helping teams to question/challenge practices and take action.”
- “I feel that it will take more than a two hour course to change someone’s values and beliefs about something. I do believe that most staff are culturally aware in any case and that this has continued the same.”
- “Training was a ‘sticking plaster’ and offered no practical advice or information.”

Tamkin *et al.* (2003) found that some participants may be hostile to training. They reported that some trainees found the training patronising and offensive. Others reported that they had never come across racism and felt that the focus on institutional racism was a personal criticism.

The employees in our survey made similar comments on their experience of race equality training:

- “...minority groups appeared to be more relevant than white British.”
- “...ignored reverse racism.”
- “I found the training day intrusive, embarrassing and only of value in terms of identifying what type of training in diversity is inappropriate.”
- “The focus on race [was] offensive as there are other issues like ageism, sexism etc.”
- “The training was very one-sided and it made you feel racist even though you are not.”
- “[The training] feels like something that is done to us rather than something that we participate in. Nature of the training is ‘us’ and ‘them’ (non-British). Training is imposed, no dialogue. If you force the issue on people they will not listen.”
- “[I] resent being told that I am institutionally racist just because I work in a large organisation. [I] resent being coerced into a politically correct gravy train.”

Summary

Race equality training has a varied status in mental health services. It is clear that legislation is a key factor in influencing the impetus for providing race equality training. Knowledge about the legal and policy context, however, seems to be located at managerial levels and frontline staff were less familiar with these documents. The findings highlight the fact that in the absence of standards for race equality training there is a lack of consistency in the training provided. For example, there was great variation in the length, purpose and content of the training. The need for a regulatory body to oversee standards and content of race equality training seems pertinent.

4

Training providers

Summary of key points

- ❖ There is no professional body that sets standards for the qualifications and practice of race related training providers.
- ❖ There is no central register for race related training providers.
- ❖ The Commission for Racial Equality (CRE) provides guidance on knowledge, skills and experience.
- ❖ There is a wide variation in the types of training delivered.
- ❖ There is no guidance as to what the required level of training should be and what it should include.
- ❖ The evidence suggests a mix of internal and external trainers is more effective, but the trend is towards using independent training consultants commissioned through informal sources.
- ❖ Diversity training was the type of training most commonly delivered.
- ❖ Just over one-third (34%) of the training providers use or had used mental health services.
- ❖ The majority (75%) of those who attended training reported that service users were not involved in any aspect of the training.
- ❖ One of the main issues in this area is the need to define 'qualifications' for service user trainers.

Introduction

The findings presented in this section are based on responses from 35 training providers. As there is no national database available to identify providers of race equality training, a snowball sampling method was used which involved asking the training providers identified to nominate other trainers who could be contacted. Sixteen (45%) of the respondents defined their ethnicity as Black, 26% white and 17% Asian. Just over one-third (34%) said they had used or were currently using mental health services. Most (66%) had been delivering race equality training for between six and fifteen years.

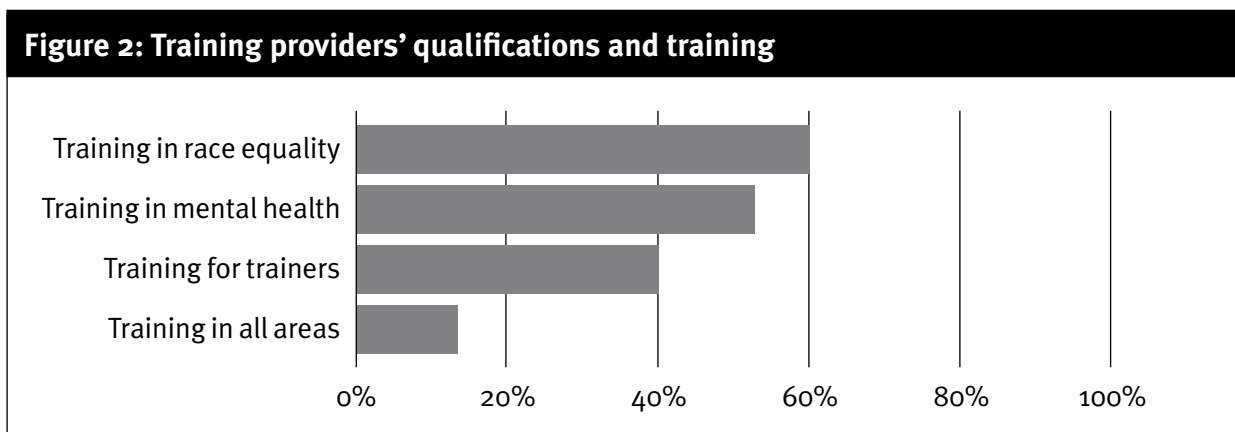
Qualifications

There is no professional body that sets standards for the qualifications and practice of race related training providers. However, CRE guidance (2006) sets out the knowledge, skills and experience to look for when selecting race equality trainers. It is indicated that trainers should be able to show that they have developed comparable training programmes and delivered them successfully. They should possess the following knowledge, skills and experience in equality and managing performance:

- ❖ an understanding of the factors affecting race equality and race relations in Britain, including demographic and cultural factors;
- ❖ an understanding of the amended Race Relations Act (1976 & 2000), particularly the statutory general duty to promote race equality and specific duties;
- ❖ an understanding of the culture of public organisations and how this affects equal opportunities;
- ❖ an understanding of 'institutional discrimination' and how to tackle it;
- ❖ knowledge of how to make race equality central to planning public services and to managing staff performance;
- ❖ experience of achieving race equality outcomes or helping public organisations to achieve them;
- ❖ interpersonal, negotiating, and co-operation skills;
- ❖ presentation skills;
- ❖ the ability to motivate and persuade people;
- ❖ communication skills;
- ❖ the ability to manage organisational change;
- ❖ the ability to deal constructively with sensitive issues;
- ❖ technical skills (using various training methods).

Findings from previous studies (e.g. Tamkin *et al.*, 2003) suggest that the credibility of trainers is generally based on their understanding of race equality issues, the organisation within which training is being delivered, and issues relevant to the participants’ work.

We asked training providers whether they had received training in race equality and/or mental health. 60% reported that they had received training in race equality, 54% in mental health care and 40% in training skills. Only 14% had received training in all three areas (see Figure 2).



The training that training providers had undertaken ranged from short courses to postgraduate degrees. Others reported expertise through experience. This raises the question of what is the required level of training and what should be included in such training?

A similar review, of race awareness training for police officers in England and Wales (HMIC, 2003), noted the difficulty encountered in determining the requirements for ‘race trainers’ as there is no standard definition of what it means to be qualified in relation to race training. It concluded that the four major concerns that needed to be addressed in relation to training providers were selection, training, assessment and support.

Who provides training?

Just under one-half of the trainers (45%) surveyed were independent providers. This reflects the general trend in race equality training where the majority of providers are independent training consultants operating within their own consultancy or working within a company that employs large numbers of trainers.

Race equality or diversity training has become a multi-million dollar industry in the US with numerous consultants, courses, books and other training materials. A similar picture is emerging in the UK. The lack of registers of ‘qualified’ race equality training providers results in an inefficient and unfair system of commissioning which is often through informal sources.

Previous work has suggested that external training providers are frequently more experienced in the broader issues of race equality while internal trainers will have a better understanding of organisational culture and practices. Thus mixed teams of internal and external trainers may be more effective (Tamkin *et al.*, 2002). Our survey found that a mix of internal and external trainers was used in a relatively small number of cases (14%). External trainers provided the majority of training (52%), while internal trainers provided around one-third (31%).

A mix of trainers from white and BME backgrounds is also advocated as a means of maintaining credibility. It is suggested that white trainers alone may lack credibility with BME staff and a BME trainer may experience defensiveness from white staff (Brown & Lawton, 1991).

However, while it is important to bring the BME experience into the training arena, it should not be assumed that staff from BME groups will be ‘the experts’ on race issues. Moreover, involvement in training could affect their credibility in other areas of their work.

Employees’ responses indicated that the general approach was that one trainer delivered training. 41% identified the trainer’s ethnicity as white and 15% said that the trainers were from Black or Asian backgrounds.

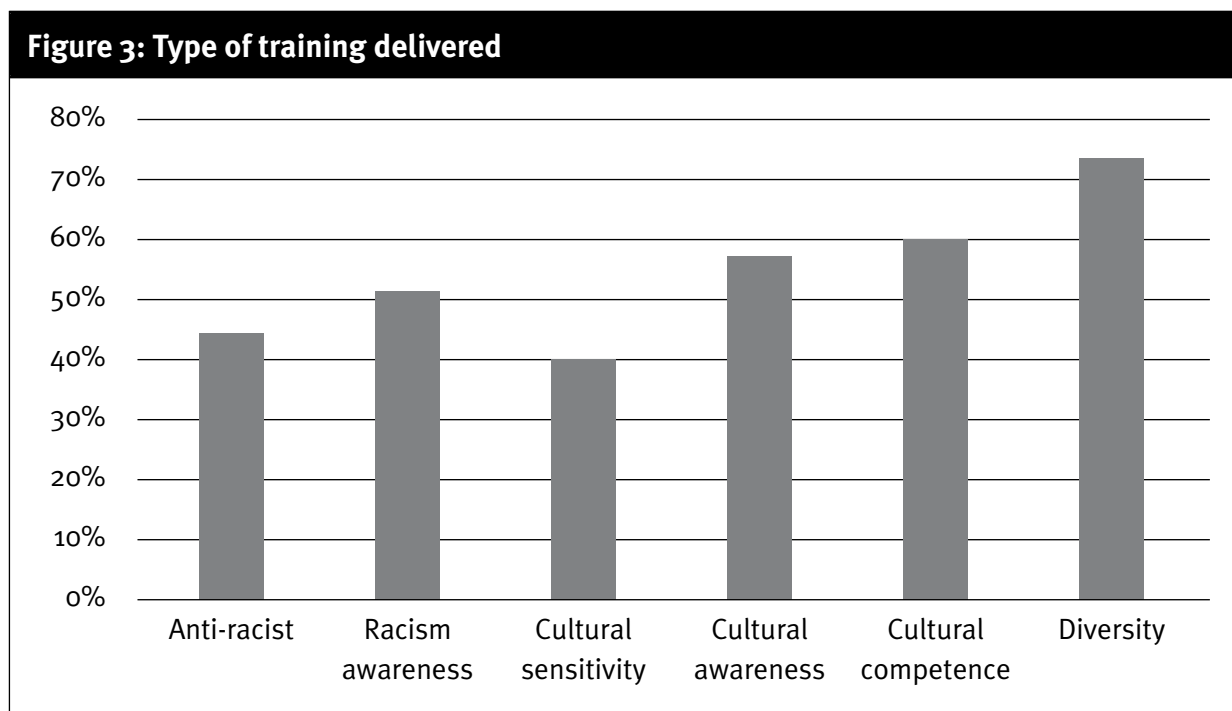
Types of training

Training providers described a range of approaches to training including diversity (74%), cultural competence (60%), cultural awareness (57%), cultural sensitivity (40%) and anti-racist training (46%) (Figure 3).

This suggests that training providers use a combination of approaches rather than following one specific model. Brown & Lawton (1991) believe that less attention should be given to course titles than

to their stated programme. They note that titles vary with fashion and even with regional acceptability of such terms as anti-racism.

The HMIC report (2003) suggests that the lack of guidance on race related training can lead to the delivery of a bland cover-all training, instead of effective training based on a robust individual and institutional needs analysis process.



Service user involvement in training

The National Service Framework for Mental Health (DH, 1999) emphasised the need to involve service users in planning, providing and evaluating training for mental health professionals. There is also guidance and examples of good practice for service user involvement in training (Tew *et al.*, 2004; Harper, 2003; Repper, 2000).

Just over one-third (34%) of the training provider respondents said they had used or were currently using mental health services. The study showed that these trainers were more likely to involve other service users in training. The majority (75%) of those who attended training reported that service users were not involved in any aspect of the training. In the minority of cases, where service users were involved, they were local service users with a small number belonging to Black and minority ethnic groups. The involvement of local service users needs to be considered with care, as they may be expected to deliver training to practitioners with whom they had contact when they were unwell. This could lead to practitioners questioning the credibility of training and increased stress for the service user involved.

One of the main issues in this area is the need to define ‘qualifications’ for service user trainers. 50% of the service user trainers in the survey had some training in mental health care. Others suggested that they considered themselves ‘experts by experience’, both through their own experience of mental health services and through their experience in delivering training.

The literature on service user and carer involvement in training generally focuses on how this can be achieved rather than on how it affects the learning of mental health professionals (Repper & Breeze,

2004). However, Tew *et al.*, (2004) acknowledge the specific knowledge, skills and experiences that service users bring into the training. They also highlight the barriers that service users may face in bringing their expertise into training, and the support that they may need, especially in learning new strategies of teaching and learning.

Service user/survivor trainers themselves have highlighted some issues relating to transferring experiential knowledge and expertise into the training environment. These include access to appropriate training, supervision and support, and overcoming discrimination (MHHE, 2003; SUSTN, 2005).

5

Evaluation of training

There has been considerable investment in and commitment to race related training for many years. Yet there is little evidence of any serious attempts to evaluate the effectiveness of race related training internationally.

In the US, evaluation is rare. Fortier and Bishop (2004) conducted a literature search to identify research that used empirical analysis to measure the impact of culturally and linguistically competent interventions. The findings revealed a limited number of published studies that employed rigorous research methodologies for each of the interventions. Studies that examined the impact of training on trainees and patients were limited. Few studies examined the impact of training on health care delivery, patient behaviour change, or health outcomes.

The only UK study identified which attempted to empirically measure the impact of race related training was that of Tamkin *et al.* (2003). They carried out an independent evaluation of the impact of community race relations training within the Metropolitan Police Authority. This was related to the findings of a review of race related training for the police force (HMIC, 2003). The review found that despite significant investment in delivering training over a number of years, the police service was unable to clearly demonstrate progress in respect of race and diversity training. The main reasons given included:

- ❖ The absence of a robust evaluation strategy nationally and locally.
- ❖ The incoherent manner in which evaluation is conducted and its lack of independence.
- ❖ The inadequate resources allocated to evaluation.

Tamkin *et al.* used the Kirkpatrick (1994) evaluation framework. This is the most established model that is used to evaluate the effectiveness of training. Evaluation is carried out at four levels:

- ❖ **Level one – reaction:** measures how participants in a training programme react to it. It attempts to answer questions regarding the participants' perceptions. Did they like the training? Was the material relevant to their work?
- ❖ **Level two – learning:** attempts to assess the extent to which participants have improved their skills, knowledge, or attitude.
- ❖ **Level three – behaviour change:** examines whether newly acquired skills, knowledge, or attitude are being used in the everyday work environment.
- ❖ **Level four – organisational impact:** this is often termed the 'bottom line' or the overall reason for the training. In this case, the bottom line would be an improvement in experience and outcomes of mental health care for BME groups.

In our survey, just over one-third (35%) of statutory sector organisations reported that they evaluated the impact of the race equality training that they provided, while half of the independent sector said that this was the case.

The majority (65%) of organisations that carried out evaluations reported that this was done internally, while 24% reported that evaluation was done in collaboration with external trainers. Only three organisations said that they involved service users in the evaluation process.

The main methods commissioners used to evaluate training were attendance at training events (76%) and participants' post-training reactions (71%). Other methods used by some organisations included attitude surveys, pre- and post-training tests of knowledge, appraisal, line managers' views and a small number mentioned using interviews and focus groups.

Table 5 shows the perceived impact of race equality training as reported by training commissioners.

Considerable positive impact	9%
Some positive impact	23%
Mixed feeling about impact	9%
Too early to tell	23%
Unable to comment	30%

The majority of training providers (91%) reported that training was evaluated. The method of evaluation that was most frequently used (71%) was immediate participant reaction to the training event using evaluation forms and questionnaires, verbal feedback and reflection exercises.

Evaluation appears to be the area of greatest confusion and least systematic action. It is often difficult to evaluate how much the training, as opposed to other measures, affects the way employees and organisations change. While it is essential to evaluate outcomes of training programmes, it is not always possible to assess directly whether a training course is effective in improving the performance of a department or organisation, as this level of change is dependent on a range of factors of which training is only one (Brown & Lawton, 1991).

6

Discussion and conclusions

This chapter discusses the broad themes emerging from the study and presents some conclusions regarding the different approaches to race equality training in mental health services. The findings of the survey are based on responses from just under one-half (45%) of all mental health services in England.

The majority (96%) of the organisations in our survey reported having a formal policy on race equality. However, a recent audit by the Healthcare Commission (March 2006) found that only 60% of NHS trusts had published a Race Equality Scheme (RES) and only 1% (7 out of 570) had fully met the requirements of the Race Relations (Amendment) Act. Only 10% had published employment monitoring statistics relating to ethnicity (Healthcare Commission, 2006).

Although most of the employees were aware of their organisation's Race Equality Scheme, many were unfamiliar with the content and the process for implementation. Managers and human resources personnel seemed to be more familiar with the RES than frontline staff. This has implications for the value and significance that staff may attach to race equality. It is important that there is a shared understanding about policy and legal requirements for race equality and the organisational strategy for achieving this.

In most cases, senior managers or chief executives were responsible for providing leadership on race equality, which is in line with the requirements of the Delivering Race Equality (DRE) Action Plan. Although most training commissioners felt that organisations gave a high priority to race equality, only a small number felt that organisations showed real commitment, particularly in areas with a small BME population.

Most organisations reported that they were providing race equality training for their employees and that this was either compulsory or strongly encouraged.

Training commissioners said that they found it difficult to estimate the cost of training but gave a figure of £10-£150 per employee plus staff replacement costs. Thus for the majority of organisations that reported staffing of over 1,000 employees, race equality training could cost £10,000-£150,000 plus staff replacement costs.

The main drivers for the provision of race equality training were compliance with race relations legislation and government policies on race equality (i.e. DRE and the David Bennett Inquiry). Although just under one half of the training commissioners said training was based on training needs analysis, training providers felt training was rarely based on the specific needs of an organisation or to improve practitioner skills and that organisations were keen to be seen to be doing the right thing, meeting legal requirements and 'ticking the boxes'.

The type of training delivered is generally determined by trainers and is rarely based on an analysis of the needs of the organisation in relation to providing equitable care to BME groups. Both

commissioners and providers reported that a range of different training models was delivered. The types of training most commonly delivered were diversity, cultural competence and cultural awareness.

The content of training focused mainly on policy and legal issues, racism and culture. Less emphasis was given to skills relevant to delivering race equality, which is a particular area of dissatisfaction for employees. One of the main problems in deciding on the content of race equality training is the difficulty in deciding which individual behaviours and attitudes, and organisational structures and processes, lead to racial discrimination, and what new attitudes and behaviours are to be conveyed in the training (Lasch-Quinn, 2001).

The majority of staff reported broad satisfaction with race equality training. Areas of dissatisfaction included lack of support after the training event, limited impact on the organisation and insufficient emphasis on practical skills to improve service delivery.

There were some employees who demonstrated some anger at the need to attend such training and were offended by the emphasis on race issues.

It was difficult to identify training providers or evaluate their effectiveness, as there are no registers or standards set for this group apart from some guidance provided by the Commission for Racial Equality (CRE). This guidance states that race equality training providers should be able to show that they have developed comparable training programmes and delivered them successfully. They should possess a range of knowledge, skills, and experience in equality and managing performance, and possess certain personal qualities such as the ability to motivate and persuade people (CRE, 2006).

In addition, training providers need to understand the organisation within which training is being delivered and issues relevant to the participants' work. The study found that although most of the training providers had been delivering race equality training for between six and fifteen years, only a small proportion (14%) had received training in both race equality and mental health care, and had also been trained as trainers.

The general trend is that the majority of race equality training providers are independent training consultants operating within their own consultancy or working within a company that employs large numbers of trainers. Training in this area has become a lucrative industry. Just under one-half of the training providers in the study were independent consultants.

The commissioning of training is often done through informal sources due to the lack of registers of 'qualified' race equality training providers. This results in an inefficient and unfair system.

Over one-third of training providers responding to the survey had used or were currently using mental health services. However, despite the emphasis in mental health policy on the need for service user involvement in training, the majority of employees indicated that service users were not involved in any aspect of the training they received. Service users can make a valuable contribution to training based on their personal experiences. However, one of the main issues that needs further consideration is the definition of 'qualifications' for service users, i.e. is the experience of using mental health services in itself sufficient?

Despite clear government policy commitment and the investment of large amounts of resources into the provision of race related training, there is little evidence of any serious attempts to evaluate the effectiveness of race related training.

The majority of training providers evaluated the trainee's immediate post-training reaction using evaluation forms and questionnaires, verbal feedback and reflection exercises. Organisations reported that evaluation was based on employees' attendance at training and on post training reaction, most of which was carried out by internal evaluators. We conclude that it is difficult to assess the effectiveness and impact of training in the absence of robust and rigorous evaluation.

Only a small number of training participants felt that it had had a 'considerable positive impact' on the organisation. Others felt there was 'some positive impact' and nearly one-third said they were unable to comment.

It is clear from the findings of the study that most of the race equality training in mental health services in England is being delivered within the framework of diversity, cultural competence and cultural awareness, with a significant emphasis on improving cultural knowledge and changing negative attitudes on race. Evaluation of the effectiveness of these approaches has shown some success in improving cultural knowledge, but there is little evidence of training having an impact on the experience of service users or on equality outcomes (Bennett, 2006).

The cultural competency literature tends to present this framework as a panacea against racism and health care inequality. While it is important to recognise that culture may play a role in health-related behaviours there is evidence that cultural competence is not in itself a safeguard against discriminatory practice. Gregg (2004) argues that "race is not culture and racism is not simply a lack of cultural competence" and that questions about disrespect and lack of care, based on how a person looks and sounds, are questions of racial bias. This approach does not acknowledge the role that racism plays in perpetuating disparities. It suggests that the problem of inequalities is the result of the person's cultural difference and not the racial bias of an institution's processes and practices.

In practice, the aims and content of diversity training vary according to the individual training provider's interpretation. While many training programmes do not use confrontational techniques, they continue to be influenced by the assumptions of the original sensitivity training approach. Cultural knowledge is provided with the main objective of changing individual attitude. This suggests racial discrimination is seen as a matter of individual attitude and practice. Such an approach is not in keeping with the requirements of the Race Relations (Amendment) Act 2000 or the David Bennett Inquiry (NSCSHA, 2003), which emphasise racial discrimination and institutional racism as the cause of inequalities.

Currently race equality training is generally seen as a single training programme delivered within a given model or framework that is appropriate for all personnel within an organisation. The feedback from participants suggests this 'one size fits all' approach does not adequately address specific issues related to their practice or the particular needs of the organisation. Some problems identified include trying to deal with complex issues of racism and cultural differences in a single training programme, and attempting to apply these to interpersonal relationships (Hemphill & Haines, 1997).

Race related training is seen as a major element in any strategy to address race inequality in the developed world. Like the US and UK, Australia, New Zealand, Canada and many European countries have all introduced some level of race related training.

The historical review has shown that race related training originated in an era when racism was overt and instituted in law. Racism was viewed as the major cause of race inequalities. As the focus on 'race' became unpopular politically, the concept of diversity was introduced as an explanation for all forms of inequality. Diversity and differences in language, religion and cultural norms and expectations are now seen as the explanation for inequality. The solution is the provision of information on different cultures (Culley, 1996).

The indication is that race related training has been significantly influenced by the changing politics of race relations. The concept of race and racism has been replaced by culturalism as an explanation for the social inequalities experienced by BME groups and is the central framework for race related training.

The current culturalist approach is widely criticised (e.g. Bhavnani, 2001) as it often focuses on the superficial manifestation of culture, including: health beliefs, values, communal rituals and shared traditions. This simplistic use of culture in public policy suggests that ethnic groups categorised as African Caribbean, Asian or white are made up of people who are all the same, in effect, having a culture that is shared and static.

A major problem facing race equality training in the future is the shift in government policy away from multiculturalism, which historically has influenced the framework for training. Multiculturalism is seen to have resulted in separatism. Emphasis is now being placed on the need for minority groups to develop core values of 'Britishness'. The move to de-emphasise cultural differences and the significant criticism, for example, of the cost of using interpreters presents a challenge for public services, which have previously focused on cultural and linguistic differences as a basis for addressing ethnic inequalities.

There is no easy way of eliminating racial discrimination in mental health. While education and training have key roles to play in developing knowledge and skills to address racial inequality, current approaches are fundamentally flawed. Race related training has generally reflected and reinforced social policy approaches rather than critically examining the limitations of current conceptions of racism. Essentially 'training for race equality' should focus specifically on areas of inequality in mental health services, such as diagnosis and compulsory detention and reducing fear etc., rather than a generic focus on culture and race. The emphasis must be on the improvement of professional practice and not merely the acquisition of knowledge on the cultures of the 'other'. Training should enable organisations and their employees to explore racial inequality within their specific context and to develop appropriate strategies to improve outcomes.

Training for race equality needs to be seen as one element within a wider organisational plan which is embedded within clinical governance systems to ensure continuous improvement in the quality of service to BME groups.

7

Recommendations

Policy

- ❖ Fundamental changes are needed in the way that race equality training is delivered.
- ❖ The Department of Health should commission and co-ordinate a programme of work which develops a template and sets national standards for appropriate race equality training, including guidance on the qualification and accreditation of training providers.
- ❖ National standards should require that training for race equality focuses on the main areas of inequality in mental health services, emphasising the impact of racial discrimination.
- ❖ Race equality training should focus on the development of professional practice emphasising interpersonal interactions between service users and practitioners and organisational processes that lead to unequal treatments and outcomes.
- ❖ Primary care trusts (PCTs), supported by strategic health authorities (SHAs), should be responsible for the performance management of provider services in meeting the Race Relations (Amendment) Act 2000 requirements and implementation of the Delivering Race Equality programme, including the provision of appropriate training.
- ❖ The Healthcare Commission should be required to assess race equality training as part of their responsibility for monitoring race equality standards. The Mental Health Act Commission in its monitoring role should assess the availability of appropriate training in race equality and application of the Mental Health Act. The regulatory body that succeeds both of these bodies should have these responsibilities built into it.

Practice

- ❖ Organisational policies and plans on race equality, including Race Equality Schemes (RESs), should specify the training necessary to achieve strategic aims. Training and strategic aims should focus on known areas of racial inequality in mental health treatments and outcomes (i.e. physical restraint, compulsory detention etc.).
- ❖ Organisations should involve their frontline staff in the development and implementation of RESs. A real sense of involvement and ownership needs to be nurtured alongside the provision of training and support.
- ❖ Race equality training should not be viewed as a single programme that can be delivered to all employees ('one size fits all').

- ❖ Training should focus on specific problems identified through clinical governance frameworks and national audits such as the *Count Me In* censuses (Healthcare Commission, 2005 & 2007) and the content should be determined by the needs of groups of staff to be trained.
- ❖ Evaluation should be resourced as an integral part of the commissioning of training. It should be designed to examine participants' learning, behavioural change and the impact on the organisation, as well as their immediate post-training reactions.
- ❖ Training providers should include service users and individuals from BME groups. But BME staff should not be viewed as 'race experts' and be expected to deliver training without adequate training and support.
- ❖ Training should be developed to support service user trainers, particularly in transferring experience into the training setting.

Research

- ❖ The Department of Health should acknowledge the need for and resource further research on race related training.
- ❖ The Mental Health Research Network should incorporate race related training into the research agenda for mental health care. Research should focus on:
 - Developing and evaluating the effectiveness of structures, processes and interventions that enable the effective delivery of the DRE programme at the individual, institutional and community level.
 - Understanding what racism means at the individual, interpersonal and institutional level and how these influence health care delivery.

Appendix 1: Methodology

Study design

A postal survey was used to access the views of a range of stakeholders on race equality training i.e. training commissioners, training providers and employees who had attended race equality training.

Defining the study population

The aim of the study was to examine race equality training in mental health services in England from the perspective of training commissioners, employees and training providers. The populations for the study were therefore defined as:

- ❖ All mental health services in England
- ❖ All race equality training providers in England
- ❖ All mental health service employees in England who had attended race equality training in the last three years.

Selecting the sample

The selection of the study sample was determined by the resources available to carry out the work, the timeframe for the study and the accessibility of the study population.

The following decisions were taken in selecting the final study sample:

- ❖ To include all NHS trusts, PCTs and independent sector services but to exclude voluntary sector services and social services departments. To include the latter services would have resulted in an un-manageable sample within the constraints of the project budget and time frame for the work.
- ❖ To use a snowball sampling method to identify providers of race equality training as there is no national database available.
- ❖ To exclude service users' views of race equality training. This was considered to be an important part of the study. However, it was felt that useful data could only be collected if it were possible to a) identify samples of service users using services where training had taken place and b) where contact with services had been maintained prior to training and for a long enough period post-training to assess the impact of training on service users' experiences. The time and processes necessary to acquire the appropriate quality of data were beyond the time and resources available to the project. However, service users participated and contributed to the study through membership of the steering and advisory groups and inclusion in the trainers' sample.

The final sample selected for the study comprised the following:

- ❖ All mental health NHS trusts and PCTs in England

- ❖ All major independent sector mental health facilities in England
- ❖ Providers of race equality training in England
- ❖ A subset of mental health service employees in England who had attended race equality training in the last three years.

Devising and piloting study questionnaires

Three questionnaires were devised to collect data from commissioners of race equality training, employees who had received training in the last three years and race equality trainers.

The questionnaires for commissioners and employees were adapted from existing questionnaires developed by Tamkin *et al.* (2002). An additional questionnaire was devised to collect data from race equality trainers.

The questionnaires were refined with input from the advisory group of race equality trainers and piloted with ten relevant subjects.

Distribution of questionnaires

A total of 2,045 questionnaires were distributed in June 2005. The breakdown of this figure is shown in Table 6.

Table 6: Distribution of questionnaires	
NHS mental health trusts and PCTs in England	80
Independent sector inpatient mental health services in England	25
Employees in statutory sector (20 x 80 trusts and PCTs)	1600
Employees in independent sector (10 x 25 inpatient services)	250
Providers of race equality training	90
Total number of questionnaires distributed	2,045

As there is no existing database of race equality trainers, a snowball sampling method was used. We sought to identify trainers through mental health service commissioners, race equality/diversity leads, trainer networks, NIMHE knowledge community website, regional development centre/race equality leads, internet searches and individual contacts.

Raising awareness of the project

A number of presentations were made at conferences, seminars and other events to raise awareness of the work. This included: the Department of Health's Mental Health Care Group Workforce Team meetings, National Institute for Mental Health in England (NIMHE) annual conference 2004, National race equality leads forum, National Psychiatric Intensive Care Unit (PICU) Network, Reaside Medium

Secure Unit, Birmingham, Dorset and Somerset SHA, West Midlands NIMHE, Huntercombe Hospital (London), South East NIMHE and East Midlands NIMHE.

Process of the study

Collaboration with NIMHE national mental health workforce programme

Collaborative working was seen as essential to ensure that developments in race equality training were adopted into existing and developing frameworks for mental health education and training.

Interim work was done in the following areas:

- ❖ An interim survey of all workforce development confederations (WDCs) was carried out to gather information on current race equality training, using a questionnaire distributed through NIMHE. The quality and quantity of the data returned were inadequate to draw any meaningful conclusions about race equality training.
- ❖ Development of the 'Respecting Diversity' element of the Essential Shared Capabilities framework for the mental health workforce, in collaboration with NIMHE and the Sainsbury Centre for Mental Health national workforce unit.

Consultation on race equality training

An event was organised in September 2004 to consult with race equality trainers. The aim was to raise awareness of the project and to explore current practice in race equality training. There were 13 attendees, with representation from various regions including Birmingham, Leicester and London. There was also good representation from the independent, voluntary and statutory sectors, as well as trainers who are service users.

Overall the group welcomed the project and felt that it was important to develop a more co-ordinated approach to race equality training. They also raised issues that needed to be addressed in the delivery and evaluation of training, which were useful in informing the development of the measures for the study.

Project steering group

A project steering group was set up to provide overall guidance on the development of race equality training. The first meeting took place in October 2004. Membership included wide national representation of key stakeholders from the Sainsbury Centre, the Sainsbury Centre/NIMHE national workforce unit, NIMHE, NIMHE National Workforce Team, service users, carers, experts in race equality training, professional bodies and the now dissolved National Health Service University (NHSU). Due to the mix of the membership and levels of discussion, concerns arose as to whether it was an appropriate forum for effective input from service users and carers. A sub-group was set up to ensure effective input from this group. The steering group was dissolved in July 2005 and a BME education and training sub-group set up within the NIMHE workforce programme. Only the Sainsbury Centre project lead was invited to join the membership of this group.

Advisory group

The members of this group were all experienced race equality trainers representing all sectors and including service users and carers who delivered training. The group was set up to support the project. Following the dissolution of the steering group, the chair and other key stakeholders continued to support the work through membership of the advisory group.

Appendix 2: Membership of steering and advisory groups

Steering group

Chair

Chinyere Inyama (solicitor in mental health law and a mental health tribunal president)

The Sainsbury Centre for Mental Health Project Team

Dr Joanna Bennett (Project Lead)

Dr Frank Keating (Senior Research Fellow)

Dr Jayasree Kalathil (Researcher)

Polly Tidyman (Project Administrator)

Errol Francis/Yvonne Christie (Programme Leads)

National Institute for Mental Health in England (NIMHE)/Department of Health

Roslyn Hope (Director NIMHE National Workforce programme)

Hugh Griffiths (Deputy National Director for Mental Health)

Professor David Sallah (National Director NIMHE BME programme)

Ian Baguley (Associate Director National Workforce Programme, Trent WDC)

Dean Pinnock (Race Equality Lead NIMHE)

Asha Day (Race Equality Lead NIMHE)

Sainsbury Centre/National Workforce Unit

Peter Lindley

Professor Peter Ryan

NHS University

Rose Barton (NHSU Interim Mental Health Subject Lead)

Dr Ian Gittens (Diversity and Equality Lead)

Gabrielle Henderson

Service users/survivors/trainers

Premila Trivedi (race equality trainer)

Dominic Makuvachuma-Walker (mental health service survivor/race equality trainer)

Carers

Nutan Kotecha
Randall Chan

Professional bodies

Dr Parimala Moodley (Royal College of Psychiatrists)
Kee Hean Lim (College of Occupational Therapy)
Nick Hinchliffe (Training Organisation for the Personal Social Services)
Jan Burns (British Psychological Society)

Experts in race equality training

Peter Ferns (Trainer)
Dr Nisha Dogra (psychiatrist/lecturer)
Mary Tilki (Chair, Federation of Irish Societies)
Dr Suman Fernando (psychiatrist)

Advisory group

Dr Joanna Bennett (Sainsbury Centre Project Lead)
Dr Frank Keating (Sainsbury Centre Senior Research Fellow)
Yvonne Christie (Breaking the Circles of Fear team lead and independent training consultant)
Premila Trivedi (service user training consultant)
Chief Omilade Oladele (traditional African practitioner and training provider)
Philomena Harris (Director of Mental Health, Salford University and trainer on anti-oppressive practice)
Dr Nisha Dogra (senior lecturer in child psychiatry at Leicester University)
Kathryn Eade (independent consultant in partnership diversity and culture training)
Anne Tucker (community co-ordinator and carer)
Aileen Alleyn (independent consultant and registered psychotherapist)
Esther Craddock (education and training advisor)
Francine Bradshaw (development consultant on BME training)
Kamaldeep Dhillon (senior researcher and co-ordinator, workforce development)
Marcel Vige (Diverse Minds)
Suman Fernando (consultant psychiatrist)
Kee Hean Lim (College of Occupational Therapy and Brunel University)

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