

Perspectives of Patients With Mental Illness on How to Better Teach and Evaluate Diversity Education in the National Health Service

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Introduction: Diversity education is a mandatory requirement for all mental-health practitioners and health care professionals in the UK National Health Service. Wide variability exists in the development, delivery, and evaluation of diversity education across health care settings, with limited evidence to suggest the optimal approach for teaching this subject. This study aimed to explore the perspectives of patients with mental illness on how to better teach and evaluate diversity education in the National Health Service.

Methods: A participatory research approach was used with five mental-health patient organizations. Forty-two patients with mental illness took part in three participatory workshops. Data were analyzed through template analysis.

Results: The findings indicated that a focus on the nuances and dynamics of clinical relationships would be beneficial. Specifically, the relationship considered most important to examine with respect to diversity education was the “practitioner–self” relationship.

Discussion: Reconstructing the relationship-centered care model with the addition of the practitioner–self relationship may be better suited to theoretically informing future developments in diversity education. Further research is needed to understand what educational approaches contribute toward a relationship-centered care outlook and how relationship building behaviors, particularly those relevant to the practitioner–self relationship are best developed in diverse settings.

Keywords: diversity education, mental-health, patient perspectives, health care, National Health Service

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Despite the frequent inclusion of the term “diversity” in educational and health care policy, considerable ambiguity remains in its definition and use.¹ Broadly, any individual difference can be regarded as diversity, including the dimen-

sions of race, gender, sexual orientation, and socioeconomic class. Diversity education is part of health practitioners’ continuing professional development and aims to equip health care professionals with knowledge, attitudes, and skills to value and respond to these patient differences. These differences have a range of implications for mental-health practice, from the ways individuals view health and illness, interpret, and respond to life experiences and the quality of clinical interactions.²

It has often been implicitly inferred that health care professionals’ ability to work effectively in a diverse population is dependent on their acquisition of “cultural competence.”^{3,4} Several definitions of cultural competence exist, the most commonly cited being “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.”⁵ In reality, cultural competence is often vaguely defined, poorly understood, and used interchangeably with a range of terms such as diversity and cultural sensitivity.⁶ Traditionally, cultural competence models emphasized the importance of developing cultural knowledge or “cultural expertise” as a way of becoming proficient in serving culturally diverse populations. However, various criticisms were made over the disregard for the inherent complexity of culture and diversity and the assumption that one could become “culturally competent” by simply learning generalized facts on certain cultural groups. Despite the progression toward the use of term diversity in recent years particularly in the UK National Health Service (NHS), most of the literature is centered on the concept of

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cultural competence. Definitional ambiguities remain in the conceptualization of the terms diversity education and cultural competence, and albeit multiple recent efforts to establish common competencies and standards for diversity education, the overall learning objectives are still unclear.⁶

PATIENT INVOLVEMENT IN TEACHING AND EVALUATION

A Lancet Commission,⁷ and the US National Institute of Health,⁸ recommended that research on improving diversity education should be based on stakeholder participation. Patient (sometimes referred to as service user) involvement is well established in certain areas of health care education in the United Kingdom, with notable initiatives in mental-health and social education.^{9,10} Health Education England¹¹ stated “*there should be mechanisms in place to ensure meaningful patient and public involvement in the design, delivery, development and quality assurance of educational programmes*” (p.28). There is evidence suggesting patient involvement has short-term benefits for all involved, where learners have reported positive remarks such as perceived relevance, improved communication skills, and increased confidence in approaching patients.^{11,12} Similarly, educators have found patient involvement increases students’ interactions and sense of familiarity with patients.¹³ Health educators have begun to reconceptualize the involvement of patients with mental illness to include sustained roles in assessment, curriculum development, and decision making.¹⁴ Notably, the UK Royal College of Psychiatrists became the first medical specialty to mandate the involvement of patients in psychiatric undergraduate and postgraduate training.¹⁵

CHALLENGES OF INVOLVING PATIENTS IN DIVERSITY EDUCATION

Patient involvement irrespective of context or discipline has remained largely passive, and its distal impact is relatively unexplored.¹⁶ Patient involvement seems to be isolated educational occurrences within the broader curriculum.¹⁷ Most published initiatives occur at undergraduate level, with limited research indicating its play in postgraduate education, especially in NHS training. Current literature on patient involvement is rarely informed by theory,¹⁸ resulting in minimal evidence to suggest what role patients should play in the process. Often patient involvement has been criticized for being stereotypical and tokenistic and absent of clear, measurable educational outcomes.¹⁹

The few existing examples of patient involvement in diversity education are confined to teaching delivery, for example, “sharing their story” and providing personal testimony.^{20,21} Additional perceived “vulnerability” and the “threatening” nature (patients expressing conflicting or “politically incorrect” views) of involving patients with mental-health illnesses is often a persuasive factor for educators in validating the inappropriateness of their involvement.^{22–24}

AIMS

Patient involvement in the development and design of diversity education has the potential to provide insight and clarity into the optimal approaches to effectively deliver and evaluate this

type of teaching. The focus on patients with mental illness is especially important as considerable evidence suggests that diversity factors can affect the accessibility, quality, and therapeutic relationships in mental-health care.⁷ Furthermore, diversity education was first made mandatory for mental-health professionals, with diversity and cultural issues being more widely discussed in this field.²⁵ This article reports on four aims relating to patients who have used mental-health services in the United Kingdom:

1. Explore their understanding of the terms; “diversity,” “culture,” and “cultural competence.”
2. Explore the conceptualization of patients’ expectations of the knowledge, skills, and attitudes of “culturally competent” health care professionals.
3. Discuss their viewpoints on current diversity education in the NHS and potential improvements.
4. Identify their perspectives on how diversity education might be evaluated.

METHODS

A participatory research approach (PRA) involves a range of methodological approaches and techniques to allow research with individuals whose experiences and perspectives are under study.²⁶ This approach was used for its flexibility in allowing methods to be adapted in accordance with patients’ needs, local context, priorities, and perspectives. A PRA is also well suited for discussing difficult and sensitive health issues²⁷ and has been found to maximize the involvement of patients in a variety of aspects related to training development and implementation.²⁸ This study was undertaken between June 2017 and November 2017.

Recruitment and Sample Characteristics

Patients with mental illness were recruited to reflect the perspectives of this specific patient group. Five mental health patient organizations collaborated in this research. All were third-sector community-based organizations that support patients with mental illness in integrating back into the community. All were based in South East England. Patients were recruited through newsletters, websites, patient forum events, and word of mouth to give rise to a purposive, convenient sample.²⁹ Sixty patients who had experienced UK mental-health services were invited to participate in a workshop; 18 individuals declined. Table 1 shows the number of participants who attended and those who declined for each workshop. We aimed to ensure a sample of diverse patients with mental illness who had either been previously or currently using UK NHS outpatient (community) mental-health services. Patients severely mentally unwell were ineligible to participate for ethical reasons because they did not have sufficient capacity to provide informed consent, meaning they were unable to understand, retain, and weigh up the information provided. Primarily, these decisions were made by the leads of the collaborative organizations, who had long-lasting relationships with the prospective participants and were able to assess capacity to consent to research. In total, there were six collaborative leads, two from each organization, who acted in the best

TABLE 1.
Recruitment of Participants

	Participants Invited	Participants Declined	Total Participants
Workshop 1	20	8	12
Workshop 2	18	4	14
Workshop 3	22	6	16
	60	18	42

interests of the patients. Their professional backgrounds were in community mental-health nursing.

Three patient participatory workshops were conducted in the months of July, September, and November 2017 with 42 participants who reflected diversity of age, ethnicity, educational background, sexuality, occupation, race, gender, and experiences of mental illness (Table 2). For the purposes of this research study, patients chose not to disclose their defined mental-health conditions. Mental-health conditions cover a wide spectrum of illnesses, and some further information could have been useful, but it was not considered essential for this research. Patient engagement was vital, and so, we provided the option not to share this.

Data Collection

A participatory workshop adopts the principles of a PRA within the format of an extended group discussion with many participants. Participatory workshops are designed primarily for three purposes that are akin to the aims of this research; (1) exploratory scoping of a subject; (2) to obtain clarity about learning needs; and (3) identify objectives of a topic or develop ideas.²⁷

Given the complexity and nuanced nature of diversity education, a participatory workshop was chosen as the method of data collection because it allows complex issues to be discussed in an in-depth supportive environment. Participatory workshops promote discussions to develop organically, thereby capitalizing on the diversity of perspectives among participants, while being structured around specific tasks, ensuring answers to the research aims are achieved. In addition, the mixture of small and larger group discussions allows for a greater exploration of individual perspectives and self-reflection in a constructive manner. Participatory workshops specifically seek dissenting views, contradictions, and an exploration of different perspectives. The aim is not to create a conflict free space, but rather an environment where conflicts are revealed, discussed, and considered.³⁰ Participants are active, not just reactive, and participatory workshops have the potential to be more creative than focus groups and can generate more buy-in than individual interviews.³⁰

Designing a Participatory Workshop

The participatory workshop was designed around four tasks, Table 3. The structure and content was piloted with a small group of patients with mental illness and modified after feedback from the research team (N.D., M.O., and K.S.; all of whom have extensive experience in mental-health research, with the one member being a patient advisor) and the leads of patient organizations. Example changes included (1) decision to frame activities within the context of outcomes from health policy documents to overcome the problem of patients struggling to answer general questions relating to their understanding of

TABLE 2.
Summary of the Demographic Characteristics of the Sample

Gender	Age	Ethnic Groups	
Male	19	21–30	3
Female	23	31–40	6
Total	42	41–50	9
		51–60	17
		61–70+	7
		African	6
		Caribbean	10
		Mixed	2
		Italian	2
		Black British	7
		White British/other	15

“diversity”; (2) decision to use flipcharts to enable participants to express their ideas as word clouds or schematic diagrams. Workshop booklets which outlined the four tasks were also used to facilitate discussions.

A mixture of techniques small and large group discussions and written feedback were used. The workshop lasted approximately 3 to 4 hours with the inclusion of a break. This mixture of techniques accommodated the diversity of patients attending the workshops, with some preferring small group discussions over larger group discussions and others more inclined to writing their reflections and comments in the workshop booklets. Each workshop consisted of the same session format and comprised consistent data collection methods, which allowed the data from the different patient groups to be compared. Audio recording was used for the small and large group discussions. The workshop booklets and flipcharts from the discussions were collected at the end of each workshop, and these written records, together with the audio recordings, were the raw data.

Ethics approval was granted by the University of Leicester and the mental-health organizations that collaborated with this study provided formal written consent as did all the participants. All identifying information has been removed from the data set to ensure the participants remain anonymous. In practice, this meant that all names and identifying features were removed during the

TABLE 3.
Study Design—Developing a Participatory Workshop

Aims of the Research	Activity Questions
Conceptual clarity of key terminology	Question 1: NHS documents state that each patient's culture should be respected and accounted for in their care. How do you understand the term “culture”? Question 2: NHS documents often state that health services must value diversity. How do you understand the term “diversity”?
Learning objectives	Question 3: What is it that patients expect health professionals' skilled in providing culturally competent care, are able to do?
Curriculum development and design	Question 4: What do you think of the current diversity education material? Question 5: What kind of education do you think would improve the care health professionals provide to patients from culturally diverse backgrounds?
Assessment and evaluation	Question 6: How can we measure the effectiveness of diversity education? Question 7: What should an evaluation tool for diversity education be seeking to measure?

NHS indicates National Health Service.

process of transcription, and participants are therefore not identifiable from the extracts of data included in dissemination.

Data Analysis

Template analysis is a style of thematic analysis that uses hierarchical coding. It is designed to facilitate a relatively high degree of thematic structure while ensuring flexibility to adapt according to the needs and priorities of the study.³¹ Central to this is the development of a coding template, which before analysis identifies salient themes related to the project aims, forming an initial coding template (Fig. 1—Part 1). The selective and judicious application of a priori themes allows important theoretical concepts and perspectives to inform the design of the research process. This is particularly advantageous for research studies that have applied concerns that need to be incorporated into the analysis. This coding template was then applied to further data, revised and refined, until saturation of the data was achieved, as congruent with the approach.^{32,33} The flexibility of template analysis ensures that a priori themes are equally subject to refinement and modification should they fail to effectively characterize the data. Therefore a priori themes are not fixed, they may significantly change during the process of data analysis to accurately depict the data.

Template analysis is well suited for larger qualitative studies exploring complex phenomena, such as diversity education, which are likely to have varied, nuanced, and multiple interpretations of a single phenomenon. Template analysis allows both a bottom-up and top-down approach, using a combination of a priori themes while actively accommodating the organic development of new themes.

Data from the participatory workshops resulted in approximately 150 to 170 pages of transcripts (of audio recordings; small and large group discussions and written feedback; workshop booklets and flipcharts) per workshop that required a minimum of 40 hours to code. Data were primarily coded by the first author (R.E.G.; PhD researcher in psychology) and collaboratively checked by other members of the research team (N.D., M.O., and K.S.) to improve coding reliability. The process for developing themes included the following core procedural stages:

- Familiarity with the data: Workshop booklets and ideas noted on the flipcharts were collected immediately after the workshops, which allowed initial themes to be explored. These were reviewed and discussed within the research team.
- Preliminary coding: The small group and large group audio discussions were transcribed verbatim. A combination of manual coding and qualitative analytical software (Nvivo) was used to retain contextual appropriateness and greater familiarity with the depth and breadth of the data. The process of template analysis began with preliminary coding of the audio and written data: workshop booklets and flipcharts which closely reflect the same process used in most thematic approaches. Themes were identified and discussed with the research team to reach consensus. In addition, a participant was randomly selected from each workshop to be involved in the preliminary coding, to improve the interpretation of the findings. All patient groups agreed diversity education should be centered on the nuances of different clinical relationships; this was not noted in the initial coding template of a priori themes.

- Developing a coding template: A coding template based on the preliminary thematic analysis was then developed for each workshop. This was compared with the coding template of a priori themes developed before full data analysis.
- Modification and refinement of coding templates: When new themes emerged that did not align to the coding template of a priori themes, modifications of the template were necessary. The exact process slightly varied with each new data set from the participatory workshop but involved new themes being inserted, existing themes being redefined, and, in some circumstances, themes were deleted if redundant.
- Comparison of coding templates: Coding templates from the three patient groups were then compared and categorized in an attempt to identify a master coding template for the findings from all participatory workshops. The practitioner–self relationship consistently arose in all of the templates. An overview of how the coding templates evolved is shown in Figure 1.

RESULTS

Three themes were identified for the broader project (summarized in Table 4), each of which had several subthemes within. The first described “*clarity of terminology*” where participants explained how they defined and distinguished between the terms “diversity,” “culture,” and “cultural competence”; basic definitions derived from the discussions are outlined in Table 4. The second theme, “*relationship-centered care*” provides a broad framework for how diversity education can be better taught and evaluated. Finally, the third theme exemplified “*improvements for diversity education and evaluation*,” highlighted issues that warrant consideration in the development, delivery, and evaluation of this type of teaching. These themes emerged in all three workshops, and there was also broad agreement across the workshops about the content and importance of the themes.

Initial coding template (Part 1)

Conceptual Clarity	Learning Objectives	Curriculum Development and Design	Assessment and Evaluation
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Second template (Part 2)

Understanding of Culture and Diversity	Relationship-Centered Care	Patient-Centered Care	Improvements for Diversity Education
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Third template (Part 3)

Conceptual Clarity	Relationship-Centered Care	Curriculum Design	Improvements for Diversity Education
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Final template (Part 4)

Conceptual Clarity on Key Terms	Relationship-Centered Care	Improvements for Diversity Education and Evaluation
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FIGURE 1. Overview of template development and revision.

TABLE 4.
Summary of Key Findings Related to the Research Aims

Clarity of terminology	<p>Diversity: Diversity was strongly associated with individuality, and generally, most participants expressed a greater preference for the term diversity over culture. Many participants said that diversity was often applied in the form of “lists or facts” about different cultural groups, thereby being used as a “label” with health care professionals failing to respond to differences in patients in their care.</p> <p>Culture: Culture was more associated with shared similarities among groups of people, whereas diversity was associated with individual differences.</p> <p>Cultural competence: Many participants agreed cultural competence cannot be pursued as a sole outcome nor achieved as a result of a single teaching session. Overall, most participants defined cultural competence as self-awareness and developing skills/attributes that underpin a therapeutic relationship.</p>
Relationship-centered care—learning objectives	<p>Professional self-development: To explore the meaning of diversity at an individual level and in relation to colleagues, peers, and patients. To develop the capacity for self-reflection, critique, and evaluation of their practitioner–self relationship. To identify personal examples of prejudice and bias and discuss strategies to challenge this effectively.</p> <p>Interpersonal skills: To develop the skills and attributes that underpin a therapeutic relationship. To develop and practice good clinical communication skills. To be able to reflect on and value the different perspectives and contribution of all health care professionals who are present in a clinical encounter. To be able to engage in an open dialog with others about areas of clinical practice they feel uncomfortable or uncertain about and develop skills to support one-another. To raise awareness of personal and institutional support systems.</p>
Improvements to diversity education and evaluation	<p>Interactive and practical sessions with small groups exploring different clinical relationships through role play, using video review of consultations, case studies, and using theater and drama. Overall, participants suggested diversity education should be personal, relational, and experiential. Participants also suggested diversity education on going, continual part of professional development for health care professionals.</p>
Assessment and evaluation	<p>Participants agreed that an evaluation tool for diversity training should be focused on measuring attitudes and skills. Useful suggestions included peer assessment, developing personal objectives, objective-structured clinical examinations, reflective and creative portfolios, examining patient complaint forms, and changes in patient satisfaction levels. Many patients strongly suggested not using questionnaires, but an evaluation tool that allows health professionals to critically reflect on the different perspectives present in clinical encounters.</p>

The second theme is reported in depth because this was the most pertinent of the three overarching themes. Relationship-centered care (RCC) is central to the second research aim and has important implications for the third and fourth aims. Furthermore, it provided a concrete and consistent perspective on how to better teach and evaluate diversity education. Discussions of the other themes are also broadly addressed.

RCC

Overall, the findings endorsed the ideas and concepts of the RCC model^{34,35} and in essence reproduced the relationships of the practitioner–patient and the practitioner–practitioner, but also added something new, namely the “practitioner–self relationship,” which is central to efforts to improve diversity education. Collectively, the findings revealed that diversity education should focus on the nuances and dynamics of clinical relationships, where the influence of both the patient and the practitioner are acknowledged and explored.

Many participants could differentiate between the notion of an interaction and a relationship, describing an interaction as a situation or occurrence in which two or more objects, events, or individuals act upon one another to produce a new effect. Conversely, the term relationship describes the way in which these two subjects interact and affect one another. Overall, the findings emphasized that relationships are associated with interpersonal interactions where there is a close and direct

connection between people who embodies health care principles and values.

Practitioner–Self Relationship

The practitioner–self relationship is a new dimension of the RCC model that emerged from this study. Many workshop participants emphasized its importance for diversity education (examples are quoted in this section). We regard this new dimension as a key addition to the RCC model, with important implications for diversity education.

The practitioner–self relationship describes the necessity for practitioners to explore, unpack, and reflect upon the meaning of diversity on an individual level and in relation to their colleagues, peers, and patients. It involves practitioners developing the capacity for self-reflection, critique, and evaluation of their identity (identities).

“I think the professional who is so called “culturally competent” is one who can look at themselves, and say this is where I am. And once you know where you are. Then and only then can you actually understand others and have good relationships with them. You have to re-educate yourself about yourself, before educating others about themselves.” (P4, W2).

Collectively, the findings showed that patients with mental illness actively encouraged practitioners to understand their

own cultural identity before attempting to understand how culture affects their patients' experiences and understanding of health and illness. Cultural competence was a well-recognized term for most. However, despite familiarity with the term, many admitted to not considering what this meant in relation to their expectations of "culturally competent" health care professionals. Dialogs initially began by trying to disaggregate cultural competence into a set of knowledge, attitudes, and skills, but as discussions matured, most participants concluded that cultural competence cannot be reduced to a fix set of knowledge, attitudes, and skills. Overall, the findings demonstrated that when attempting to establish patients' expectations of "culturally competent practitioners," their discussions reached consensus on the expectation that professionals would be proficient in the skills, values, and attributes that underpin, what they collectively described, as the "practitioner–self relationship." These included self-awareness, interpersonal skills, communication, trust, empathy, and respect.

"They should be culturally competent to know what you need, what I need, and what somebody else's needs, understand and respond to differences. I'd just want to be treated like a human being with someone who cares for me, it's the relationship we want." (P12, W1).

Several patients stated terms like "cultural competence" detracted from the basic self-awareness and interpersonal skills needed to effectively respond to diversity issues. Most participants agreed that attributes of a culturally competent practitioner reside on a changing continuum of desirable attitudes and skills, which are conducive to professional self-development and interpersonal skills.

However, many reflected upon how challenging and uncomfortable exploring the practitioner–self relationship can be, especially in relation to diversity as it "*forces practitioners outside of their 'comfort zones'*" (P6, W2). Many patients expressed uncertainty on how to create a safe and supportive learning environment to truly examine the practitioner–self relationship and for educators delivering diversity education to also examine themselves. Suggestions included using video reviews, self/peer-review appraisals and reflective portfolios.

"I think what gets into the way of that is that there are people that are not able to honestly look at themselves and that process might be very painful. A lot of people they don't know who they are. And they won't accept that they have biases towards one or the other." (P10, W3).

Practitioner–Patient Relationship

All groups recognized the patient and practitioner as cultural beings, who bring their own unique cultural background to clinical encounters, which influence the nature and meaning of their relationships with each other.

Many patients claimed cultural differences, and diversity issues can hinder the formation of a therapeutic practitioner–patient relationship by creating a cultural distance, resulting in both the patient and practitioner feeling frustrated, not understood and dis-satisfied. The relationship between them was seen as the vehicle for bridging cultural differences and a platform from which learning from and with each other took place:

"To make the training more like what happens in practice for both sides. There are two of us, and we depend on each other, health professionals and patients. Understanding how to form relationships with different people? How co-effect and co-learning takes place between the health professional and patient? Cultural competence or diversity is not one-sided. It's not that, you learn or they learn, it's a two-way street." (P9, W2).

Racial or ethnic concordance between the practitioner and patient was discussed in all groups, positioned as a way of cultivating a better practitioner–patient relationship.³⁶ A few participants expressed a strong preference for having racial concordance to create a better relationship, thereby suggesting a difference in race may result in a perceived cultural distance between the patient and practitioner. Yet, they rarely considered that cultural differences can arise even among patients and practitioners of the same race, as shown below. Interestingly, many patients often appeared to not recognize that they too make assumptions about their practitioners and others.

"Participant 3 (W2): No disrespect, who do you think you're going to see first? You're going to see an Asian doctor straight away. And you're expecting them to be culturally competent? It's not going to work is it? So what we're supposed to speak, know and learn about their language in a British country. We need to close the gap and see more West Indian doctors."

Participant 2 (W2): I've seen West Indian doctors and as a West Indian I don't think they understand me any better. The only way to understand me better is to ask me."

When all patient groups were devising learning objectives, they cohered on valuing and developing skills of working in partnership, shared decision making, holistic care, communication skills, empathy, and attributes that again underpin a therapeutic relationship and closely resonate with the principles of patient-centered care. Communication was reported as an integral aspect of diversity education, particularly akin to the practitioner–patient relationship. Effective communication skills and self-awareness were repeatedly stressed as essential tools for bridging cultural differences, understanding one another, facilitating respectful curiosity, and developing and maintaining a caring and compassionate relationship with patients. Many participants recommended exploring the practitioner–patient relationship through experiential techniques such as role play, discussion-based case studies, and using forum theatre/drama to emulate and explore different clinical situations in a safe and supportive learning environment.

Many participants reported experiences where practitioners were more inclined to make assumptions about their diversity as opposed to asking them. The reasons for this varied according to individual experiences, but included fear of offense, the notion that professionals should already know about their patient's diversity needs, and a superficial understanding of the complexity of cultural and diversity issues. Many described experiences of how a professional's unquestioned assumptions governed their relationship and the care provided.

“It’s quite funny actually when I’ve been in hospital I’ve experienced too much cultural needs and diversity, because my name is a Jewish name, Aaron and they automatically assumed that I’m Jewish. So the first thing I get is a kosher meal, well I’m not actually Jewish, my dad’s Jewish, I’m not. I’ve chosen to be a Christian. The problem is they don’t ask, they assume. There are a lot of automatic assumptions rather than actually asking the individual.” (P11, W3).

Practitioner–Practitioner Relationship

Generally, the findings highlighted the importance professional relationships among colleagues (termed the “practitioner–practitioner” relationship) in supporting one another in understanding shared notions on professional identity and encouraging each other to value diversity. Many participants raised concerns that the relationships between colleagues affect patient care and how diversity is responded to.

“The way colleagues treat each other can impinge on the treatment that a patient is getting, if you’re not agreeing with your colleagues or being asked to do something that you’re not happy with or you’re being told to do it in a way that is offensive, could have a knock effect on the way you treat patients, so those interactions are important for the professional in developing themselves too.” (P5, W2).

The findings also described the necessity of staff support, self-care, and team working. Some gave examples of the NHS health care system being a hostile environment for RCC. The lack of time, increasing pressures and modernization have detracted from clinical relationships and diversity, is perhaps viewed as an “*additional, unwanted problem*” (P7, W3). Several patients greatly emphasized the importance of staff caring for themselves and their colleagues and for good relationships to begin among practitioners who subsequently fosters good relationships with patients. Increasing pressure and time constraints may result in practitioners perceiving diversity issues as low on the agenda. Many participants stressed the importance of developing communities of care in health care systems and being aware of support systems and coping mechanisms.

Evaluation

All patient groups agreed that diversity education should be evaluated by measuring changes in one’s attitudes and skills. The findings suggest that an evaluation tool for diversity education should be contextualized, use clinical scenarios, and be appropriate for all health professionals. Several participants from all groups strongly demonstrated their concerns about the validity and effectiveness of using traditional methods such as questionnaires and feedback forms in measuring the complexity of diversity issues. Many participants strongly advocated against the use of questionnaires and suggested seeking alternative methods to evaluate diversity education. Several evaluation tools were discussed for diversity education. These included videotaping of consultations, objective structured clinical examinations, and reflective journals. However, several participants were active in identifying the limitations of each tool and concluded that multiple evaluative tools should be used.

A few mental-health patients proposed asking health professionals to develop “personal objectives” on diversity, outlining what they would change about their clinical practice from

the education they received. Other useful suggestions included peer assessment, reflective and creative portfolios, examining complaint forms and changes in patient satisfaction levels.

DISCUSSION AND CONCLUSION

The findings from this study demonstrated a discernible pattern of common themes for how diversity education can be better taught and evaluated. The centrality of relationships in health care practice and in diversity education was salient and a core feature of the final template. Multiple accounts showcased participants’ reflection and attention to the reciprocal and meaningful influence the patient and practitioner had on each other, and the important role patients play in informing the field. The findings illustrate that each is an observer of the other; each interprets and constructs a subjective world, and these worlds are modified by the dialog between them and the nature of their relationship.

The topic of relationships is rarely included in theoretical frameworks exploring cultural competence or issues of diversity, hence its absence in the inclusion of a priori themes in the initial coding template. In comparison with the array of theoretical frameworks used in diversity education, the findings were most closely consistent with the RCC framework^{34,35} that has not been fully exploited in diversity education. Although the RCC framework values self-awareness and emphasizes the capacity for practitioners to be reflective and critical, it does not explicitly define the importance of the practitioner’s own self relationship as a separate dimension. When participants were attempting to establish their expectation of “culturally competent practitioners,” their discussions assumed that professionals would be proficient in the skills, values, and attributes that underpin a good therapeutic relationship. Participants’ principal expectation was that practitioners would have a better understanding of themselves. This is consistent with theoretical frameworks that represent a departure from traditional cultural competence models (ie, cultural humility and cultural sensitivity) where understanding oneself takes precedence over gaining knowledge and expertise about others.^{37,38}

Recent research illustrates practitioners impact on patient experience in health care, demonstrating that practitioners are not immune from harboring stereotypes and biases toward their patients, which can adversely affect the therapeutic relationship.³⁶ This can be especially important, given the historical criticisms regarding the power held by mental-health practitioners and the subordinate role played by patients.³⁹ The relationships between practitioners and patients are a central and important one, with the new dimensions of patient-centered care having an important contribution to make in diversity education. Traditionally, research in diversity education has focused on the importance of the patient’s culture to the neglect of the practitioner’s culture.^{40,41} Many authors criticize that this approach can distract practitioners from self-reflecting on their own culture and may actually perpetuate stereotypes.⁴² Literature on raising self-awareness and reflection among practitioners has particular relevance in this study.^{43,44}

Overall, the findings provide supporting evidence for the theoretical progression away from knowledge-based cultural competence models to process orientated models, emphasizing self-development and awareness. In a recent study, Hordijk

et al⁴⁵ devised a framework of agreed competencies for diversity education through discussions with a range of medical educators and found the three competences that received the most consensus (over 90%) were (1) ability to critically reflect on one's own values and beliefs; (2) awareness that teachers are role models in the way they talk about patients from different ethnic, cultural, and social backgrounds; and (3) ability to communicate about individuals from cultural groups in a non-discriminatory, nonstereotypical way. The emphasis on reflexivity and self-awareness in this study strongly supports the findings and demonstrates that both medical educators and patients value and agree upon specific competencies for diversity education. In contrast to conventional notions of diversity education, this study deviates from the traditional practice of learning about others to first learning about oneself to better understand others.

The meanings of culture, diversity, and cultural competence were all closely associated with identity. These findings are strongly consistent with the notion of "intersectionality," a term coined by Kimberley Crenshaw⁴⁶ to describe the multiple components of one's social identities (ie, gender, social class, race etc.) and how they overlap or intersect with one another. However, contrary to the traditional notion of intersectionality, the findings place greater emphasis on the context and the relationship between individuals in defining how the intersections in one's identity are formed and maintained. Theories of social identity may be more compatible with the findings as they similarly describe the internal experience of how we see ourselves in relation to others, as well as the different ways one can categorize, position, and align oneself with others.⁴⁷ Despite the array of descriptions on self-reflective practice, little attention has been given to reflection *before* action, which may help practitioners recognize the importance of contextual factors and consider any assumptions or unconscious biases they may have.⁴⁸

All 3 patient groups expressed their concerns with the challenges practitioners face in practicing self-awareness and reflection on their own culture and diversity. This has been defined in the literature as the "*anthropological paradox*"⁴⁹ that describes the difficulty in actively defining and recognizing one's own culture and to objectively critique the subjective nature of one's practices and assumptions. This difficulty may account for why culture for the large majority remains a vague concept, especially for those individuals whose cultural practices and norms are less explicitly defined. The development of the practitioner-self relationship cannot be achieved in a single diversity education session. Educators must create frequent opportunities to reflect upon challenging situations that create perplexity, hesitation, and doubt or otherwise described as "disorientating dilemmas,"⁵⁰ "inner discomforts"⁵¹ or uncertainties to precipitate any kind of learning on self-reflection and awareness of one's own diversity.

Little research has explored the influence and impact of diversity educators' values, beliefs, and perspectives on how diversity education is understood and taught.⁵² Research largely shows that educators have limited training on diversity, resulting in them feeling insecure and unprepared, lacking adequate knowledge and skills to teach this topic.⁵³ Many health educational institutions provide little formal leadership in conceptualizing and framing diversity education, despite the widespread practice of this type of teaching.⁵⁴

The complexity and sensitivity of diversity education requires a greater understanding of how to create a supportive environment in which to facilitate and constructively explore participants' own culture, biases, and assumptions. The findings suggested diversity education should be personal, relational, and experiential. Practical/case-based teaching was recommended in helping practitioners actively contextualize, explore, and critically evaluate diversity issues in the context of different clinical relationships, thereby enabling practitioners to reflect upon their judgment and ability to deal with uncertainty.⁵⁵ Didactic methods generally monopolize the teaching of diversity education; however, the findings advocated the use of role-play with simulated patients in developing communication skills, case studies, reflective portfolios, and problem-based learning. Hordijk et al's⁴⁵ study revealed a core competency required by faculty teaching diversity was the "*ability to engage, motivate and let all students participate in the learning environment.*" (pp.3) The importance of inclusive learning was not raised in this study, and little research explores the application of inclusive practices in curriculum development and design. However, adopting inclusive pedagogical approaches seems complementary in the teaching of diversity education, and further research may assist in embedding diversity education throughout the health care curriculum.⁵⁶ Furthermore, the co-creation of curriculum with patients will support educators in ensuring the patient voice is embedded in teaching materials and delivery.⁵⁷

Evaluating the desired attributes outlined in the practitioner-self relationship is challenging. Traditionally, diversity education has primarily used self-reported measures to evaluate cultural knowledge, attitudes, and skills to demonstrate the effectiveness of these initiatives.⁵⁸ This approach has been consistently questioned, particularly with reference to the emphasis on measuring cultural knowledge as being primarily indicative of health professionals' ability to effectively respond to and manage cultural diversity issues.^{3,4} Participants collectively highlighted that although questionnaires are often a practical and feasible option, they are prone to issues of bias and social desirability and are unable to fully capture the complexity of diversity issues. Situational judgment tests may be a suitable method of evaluating diversity education, as they are less susceptible to social desirability and "faking" and are consistently used to measure personal attributes such as self-awareness. Although not traditionally used for diversity education, extending the application of situational judgment tests for evaluating these types of teaching may provide a beneficial resource for future researchers on measuring nonacademic, personal attributes.

The practitioner-patient (often referred to as the "doctor-patient" relationship) is the most widely explored type of relationship in health care and fundamental to patient care. Research exploring patient perspectives on clinical consultations suggest that many practitioners have a limited capacity to "sense meaning," especially at affective, cultural, and spiritual levels.⁵⁹ Participants reported that cultural differences were significant variables in impeding the development of a therapeutic relationship as the ability for practitioners to sense meaning became increasingly distant and detached from who they are and their experience. A few participants questioned whether ethnic/racial concordance between the doctor and the patient could help facilitate shared

meanings and better relationships. It is unclear whether the lack of cultural similarities or our inability to recognize, adapt, and relate to different patients' cultural and diverse needs is the source of perceived social distance in the patient-practitioner relationship.

In reference to the wider literature, the notion of "cultural distance" raised in this study closely matches the well-known sociological idea of "social distance."^{60,61} Kadushin stated that social distance can have both advantages and disadvantages in maintaining stable interactions where both closeness and understanding and objectivity and detachment are essential to the practitioner-patient relationship. Conversely, the findings suggest there is a greater need for closeness and understanding in health care relationships both in general and particularly in diverse settings.

Overall all groups emphasized the way in which practitioners respond to diversity is often mirrored in how they see other practitioners respond to diversity issues, even if this might seem contradictory to one's own personal or professional identity. Compared with the vast array of literature on the practitioner-patient relationship and its influence on patient outcomes, the quality of the relationships between practitioners has received little attention from researchers. The benefits of collaborative team work are well documented in the literature,⁶² and consensus exists among regulatory bodies that doctors should possess interpersonal skills to work in diverse multiprofessional teams and adapt to changing societal expectations.⁶³ Specifically, Shortell et al⁶⁴ found that team culture was significantly associated with better outcomes of care. As the health care population becomes increasingly diverse, shared agreements on clinical practice are more likely to differ and the significance of relationships among practitioners will become increasingly important.

Practice Implications

Although this study focused on improving and evaluating diversity education in the NHS, many of the challenges and issues encountered may be similarly applicable to other health care settings and international contexts.⁶⁵ The findings were neither specific to the context of mental-health nor the NHS and while the data were generated by patients with mental-health illnesses, and caution must be exercised in extrapolating the salient issues identified by them, it is arguable that these issues could be transferable to other settings such as undergraduate medical education, and therefore, further research is required. For example, the findings exemplified the importance of meaningful relationships with patients and practitioners in defining the contents of diversity education, with transparent learning outcomes and teaching methods, and it is likely that this is also important in other settings. These findings can potentially be incorporated in health educational curricula and teaching activities designed to foster self-awareness and reflection. Studies such as White et al,⁴² Saunders et al,⁴³ and Mann et al⁴⁴ provide concrete examples of different pedagogical methods and teaching exercises to foster self-awareness and the attributes described in the practitioner-self relationship. However, for this to be applied in practice, health care practitioners would need to embody a collaborative environment in which relationships and relationship building skills are valued and prioritized. Framing diversity education within the context of first exploring the

practitioner-self relationship to better understand and relate with others may be an optimal approach for how to better teach and evaluate this type of teaching. The additional dimension of the practitioner-self relationship could be used to reconstruct the existing framework on RCC. Furthermore, the direct involvement of patient narratives and perspectives to inform diversity education and arguably other forms of practitioner continuing professional development could provide more in depth, realistic training.

The method of using a participatory workshop was highly successful in engaging a diverse group of patients and gaining relevant information to support curriculum development and evaluation of diversity education. Greater utilization of this approach may be beneficial to explore further with regards to involving patients in research and education. Many examples of poor patient involvement are being implemented under the rhetoric of diversity education; however, these findings suggest when involving patients in diversity education, patients must have a defined role and task for their involvement to be meaningful. A disclaimer must also be made that one patient's personal story about a diversity issue is not representative of all patients' experiences with that particular issue, and patients and practitioners must be willing to learn from and with each other.

Limitations of the Study

A common limitation of qualitative research is the difficulty of generalizing the findings, as to replicate the exact research process in wider populations is challenging to achieve. The structured format of the participatory workshop with set tasks and large sample size attempts to reduce this limitation and make it easier to replicate. Furthermore, sampling adequacy was achieved for the approach and theoretical position of the study. Nonetheless, the extent to which these findings can be extrapolated to wider populations requires further work, and a synthesis of qualitative research in this area would facilitate translation. This study only involved patients with mental illness; therefore, the data may only reveal a partial view of this issue. Complicating matters further, as the exact nature of the mental illnesses was not disclosed by participants, it is not possible to speculate as to how the characteristics of those conditions may influence perceptions. The term mental illness covers a wide spectrum of disorders, and we may have generated some valuable data which illustrate the complexity of diversity education, had we obtained specific diagnostic information. Further research with diverse patient populations may indicate different results. However, the findings from this study indicate that the relationship-centered care approach, particularly the practitioner-self relationship, warrants further attention.⁶⁶

Conclusion

Health care services continue to become more complex, diverse, and specialized. Diversity awareness, values, attitudes, knowledge, and skills cannot be imposed. These realities must be considered, experienced, developed, and owned. This research identified consistent perspectives from a large sample of patients with mental illness on how diversity education can be better taught and evaluated. The findings suggest that the aim of diversity education should not be to learn about others but to learn about oneself, to facilitate a better understanding of others

in how they are similar to or different from oneself. Future developments in diversity education must be educationally informed; comparing the effectiveness of different educational models used to deliver diversity education would assist in providing educational clarity. The practitioner–self relationship warrants further research, and greater empirical exploration is needed to understand what educational approaches lead to a RCC outlook and how relationship building behaviors are best developed and fostered in diverse settings.

Lessons for Practice

- Considerable ambiguity remains in the definition and use of diversity in health educational settings.
- Limited research exists to suggest how patient perspectives, particularly those with mental illness have been incorporated into current diversity teaching.
- The practitioner–self relationship is a new dimension of the RCC model that emerged from this study. The findings indicate that the starting point to understanding the complexity of what diversity brings to clinical settings resides with first understanding oneself.
- Diversity education should assist health care practitioners in developing greater self-awareness and reflection of diversity on an individual level and in relation to others and highlight the value of building relationships in diverse settings.

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Informed consent and patient details: The authors confirm that all patient/personal identifiers have been removed or disguised, so the patient/person(s) described are not identifiable and cannot be identified through the details of the story.

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