



CPD Online take-home notes

Diversity training for psychiatrists

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Cultural identity may be affected by many factors such as:

- race
- ethnicity
- age
- language
- country of origin
- acculturation
- sexual orientation
- gender
- socio-economic status
- religious/spiritual beliefs
- physical abilities
- occupation.

These factors may impact behaviours, which in turn can influence how patients and health care professionals perceive health and illness, and how they interact with one another.

A multifactorial definition of culture suggests that individuals draw upon a range of resources, and that, through the interplay of external and internal meanings, they can construct a unique sense of identity and culture.

Problems that may arise from doctors and patients misunderstanding each other's perspectives include:

- lack of knowledge – resulting in an inability to recognise the differences
- self-protection/denial – leading to an attitude that these differences are not significant, or that our common humanity transcends our differences
- fear of the unknown or the new – because this is challenging and perhaps intimidating to understand something new that does not fit into one's worldview
- feeling pressured due to time constraints – which can lead to feeling rushed and unable to look in depth at an individual patient's needs.

These things in turn may lead to:

- patient-provider relationships being affected
- miscommunication
- non-compliance and not understanding the patient's perspective
- rejection of the healthcare provider

- conflict or isolation within staff groups.

Legislation

It is illegal to discriminate on the basis of:

- race/culture
- religion
- sex
- disability
- age
- sexual orientation.

Since the introduction of the Race Relations Amendment Act 2000, the onus has shifted onto organisations to show that they are not discriminatory. Until then, individuals had to prove they were discriminated against. This is why, in part, there has been an increase in training.

It is unlawful to discriminate either 'directly' or 'indirectly' on the grounds of sex, race or marital status.

Direct discrimination occurs when a person is treated less favourably on grounds of sexual orientation, race, religion or belief than others were, or would have been treated.

Discrimination on racial grounds can include colour, nationality, citizenship, ethnic or national origins.

Indirect discrimination occurs when:

- a provision, criterion or practice is applied to everyone – but as a result, certain people (i.e. of one type of sexual orientation, marital status, race, religion or who hold certain beliefs) are at a disadvantage compared to other people
- the individual complainant can show that s/he suffered that disadvantage – and the provision, criterion or practice cannot be shown to be justifiable as a proportionate means of achieving a legitimate aim (an appropriate response to a business need).

Discrimination does *not* occur where, having regard to the nature of the employment, or the context in which it is carried out:

- being of a particular sexual orientation, marital status, race, religion or holding a certain belief is a genuine occupational requirement
- applying that requirement is in proportion to the employer's need in that particular case.

Interventions

Few interventions have been shown to be effective in improving care for minority groups thus far. In the US there is strong evidence that aiming to improve quality overall helps narrow the gap between different groups, although it does not eradicate this gap altogether.

Strategies for delivering services at an individual level

It is good practice in assessment to:

- be aware of your own world view and that of your patients and their carers
- take into account the patient's explanatory models of their illness
- be aware that patients are individuals and even two members of the same family may have very different perspectives.

Strategies at a team level

As part of recent training within Leicestershire CAMHS, the basic points that were agreed and put into practice were:

- giving basic information (including welcome info)
- the formulation of cultural needs post-assessment and auditing of this process
- the introduction of prompt sheets/standardised assessment tools to include cultural needs
- team case discussion – ensuring the issue of culture is raised, asked about and recorded
- at the end of the assessment, asking if the needs of the patient were met
- keeping a written record of the reflective process demonstrating the recognition of the patient's cultural needs/beliefs/perception
- finding out about good practice elsewhere that has changed the service user and clinician experience for the better.

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