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Diversity Training in Children and Youth Mental Health Settings:

A Review and Evaluation of the Literature

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Introduction

Early childhood and youth mental health settings are becoming increasingly diverse in terms of language, ability, education, class, demographics, and ethnicity (Horm, 2003). As a result, the need for diversity training has received greater attention (Antinori & Moore, 1997; Ecklund & Johnson, 2007; Pumariega, Roger, & Rothe, 2005). Despite this growing need, previous reviews indicate that diversity training is seldom designed according to established theory or empirical evidence, and that there is a lack of evaluation and follow-up to measure the impact of this training (Paluck, 2006; Robertson, Kulik & Pepper, 2001). Furthermore, few of the programs, workshops, and courses which have been empirically evaluated are subjected to assessment methods beyond student feedback and participant satisfaction (Crosson, Deng, & Brazeau, 2004; Dogra & Karim, 2005). There is also a need to investigate whether diversity training makes significant changes, not only in staff perceptions and awareness, but also in the quality of service provision and client outcomes (Dogra, Vostanis, & Frake, 2007). This knowledge is particularly imperative in the child and youth mental health field, where a lack of cultural competence can lead to misdiagnosis, high drop-out rates, poor clinical outcomes, non-compliance, poor use of health services, and alienation of the child or adolescent and their family from the mental health care system (Anderson, Scrimshaw & Fullilove, 2003; Delphin & Rowe, 2008; Kim, 1995; Kripalani, Bussey-Jones, & Katz, 2006; Webb and Sergison, 2005). This review summarizes the common approaches used to increase diversity awareness and cultural sensitivity in the workplace, and presents an overview of the studies which have evaluated these approaches. Components of effective training programs are also be highlighted, followed by a discussion of the limitations of the current research and suggestions for future research to improve the evaluation and effectiveness of diversity training.

1. Methods of Diversity Training

Diversity training focuses on addressing social problems such as race and gender relations, promoting positive group interaction, improving the workplace environment, and eliminating racism, sexism and other forms of discrimination (Fowler, 2006). It involves increasing awareness of these issues, and helping people to value differences (Paluck, 2006). Diversity training is offered in numerous fields and organizations, and is usually aimed at improving employee relations (Karp, & Sammour, 2000). In the mental health and health care field, this type of training is often referred to as cultural competence training, which deals with the client-practitioner relationship, and how to effectively provide health, mental health, and general services to diverse populations (Antinori, & Moore, 1997; Sue, 2003). It has also been defined as a process of developing knowledge, skill and sensitivity about the unique qualities of the client in the contexts of the individual, family, organizational system, and culture (Watts, Cuellar, & O'Sullivan, 2008). In all work fields, literature suggests that there are several different approaches that can be used to increase diversity awareness and cultural competency. These approaches are best summarized by the following four categories: awareness training, knowledge acquisition, skills training and experiential learning. Diversity training typically incorporates one or more of these components.

a. *Awareness Training*

Awareness training focuses on changing participant attitudes and beliefs (Hite & MacDonald, 2006; Sue, 2003). Activities that reveal stereotypes are often included in training, and personal awareness about one's own culture and the culture of other ethnic groups is expanded (Sue, 2003). Becoming cognizant of one's own biases and values, and building comfort with differences is also an important aspect of increasing awareness (Sue, 1991). Instructional measures such as videotapes, group discussions, PowerPoint presentations, role plays, and workbooks are often used for this type of training (Hite & MacDonald, 2006). For example, some diversity training programs require that participants record their reactions to course content in a journal format, which gives them an opportunity to reflect on their own beliefs and biases (Anderson, Calvillo & Fongwa, 2007).

b. *Knowledge Acquisition*

Knowledge training focuses on the acquisition of information about values, worldviews, beliefs, social norms, history, experiences, and lifestyles of other cultures, and how they affect cultural groups (Sue, 2003). These programs often focus on definitions of culture, and related concepts (Anderson et al., 2007). Information about equal opportunity laws, policies on gender harassment, cultural styles, ways of communicating, and cultural minority groups is given in order to dispel common myths and stereotypes (Paluck, 2006). This knowledge is usually translated in the form of lectures, audiovisual representations, or interviews with experts and consultants (Sue, 2003; Paluck, 2006).

c. *Skills Training*

Skills training involves providing staff members with specific information that they need to make the behavioural changes that are required to manage and work within a diverse workforce (Wentling & Palma-Rivas, 1998). For example, important skills in the mental health care field that are often emphasized as part of cultural competence training include communication skills, the ability to interact with and understand clients, the ability to respond to verbal and non-verbal messages, the effective use of an interpreter, and the consideration of cultural cues (Pumariega et al., 2005; Sue, 2003). The training format for skills training usually involves role-playing, workshops, language training, and immersion programs (Sue, 2003; Wentling & Palma-Rivas, 1998).

d. *Experiential Learning*

Training that involves experiential learning incorporates direct experience with individuals from various backgrounds, as well as time to think, reflect on, and process these interactions (Horm, 2003). It has been found that experiential learning results in more learning and change than traditional coursework alone, and generates increased sensitivity to cultural and family contexts (Horm, 2003). It has been proposed that experiential methods promote healthy interaction across groups by providing employees with an opportunity to travel to neighbourhoods of a different economic or ethnic background where they can practice communication techniques, observe interactional styles, engage in group discussion, and participate in role-playing exercises (Paluck, 2006). In order to enhance experiential learning, Kim (1995) recommends that clinicians receive ongoing caseloads of minority children for diagnostic and treatment purposes.

Clinicians can also be encouraged to visit ethnic-oriented community mental health centres, medical clinics, churches, daycare centres, community services and ethnic community events (Kim, 1995). Attending these events allows staff members to learn community values, concepts and practices first-hand, and also reinforces classroom learning (Anderson et al., 2007).

It has been suggested that the most effective form of training depends on the specific needs of the organization; however, several researchers emphasize the importance of teaching applied skills in addition to awareness training and knowledge acquisition (Anderson et al., 2007; Fowler, 2006). Although awareness and knowledge are important first steps in diversity training, there is some evidence to suggest that these methods may not provide employees with the skills that they need to implement what they have learned. For example, Hite and McDonald (2006) conducted qualitative semi-structured interviews with administrative staff from several types of industries, including health care, government, non-profit entities, manufacturing, and insurance. Most of the training methods identified by individuals in these organizations were classified as "awareness level" training. Although these programs were found to have a good reputation among participants and were well received by the organization, some stated that providing awareness level training alone was a limitation, and expressed a need for more advanced methods to build beyond awareness and support employees in applying their knowledge (Hite & McDonald, 2006). Similar findings were reported by Ton, Koike, Hales, Johnson, and Hilty (2005), in their study which evaluated in-service training provided to forty-three mental health clinicians and program directors on issues such as "Use of an Interpreter", "Cultural Issues in Cultural Psychiatry", and "Cultural Competence 101". These mental health professionals reported that they felt a greater appreciation for cultural issues after the program, but stated that they and their colleagues remained ineffective in addressing these issues with clients during treatment and wanted training that was more meaningful and practical.

In contrast to these findings, Webb and Sergison (2003) found that awareness training can be useful if the focus is on understanding as opposed to knowledge attainment. Their study evaluated a one day cultural competence training workshop delivered to multi-professional staff that provided a structured opportunity for trainees to explore attitudes, recognize how they and their clients are influenced by culture, and how racism can affect service delivery. Training emphasized self-reflection, self-awareness, and acceptance of differences, rather than delivering information about cultural groups and norms. A majority of the respondents found the training helpful, and declared that it met most of their needs. They were also satisfied with the amount of practical information given, and felt slightly more confident in providing care to their patients. Many also responded positively to questions concerning changes in behaviors and questions, and increased effective communication with parents. This suggests that awareness training may be useful when there is less emphasis on delivering cultural information about norms and differences among groups, and when practical information is given (Webb & Sergison, 2003).

There is also evidence to indicate that portraying certain groups as having particular values, beliefs, and behaviours, and emphasizing knowledge of differences rather than diversity within groups may reinforce stereotyping behavior (Dogra & Vostanis, 2005;

Anderson et al., 2007). For example, Sanchez and Medkik (2004) found that coworkers of managers who attended a diversity training workshop focused on increasing knowledge were more likely to report incidents of differential treatment than coworkers of a control group. The strength of this study is that it measured not only participant satisfaction, but the effects of training on employee behaviour and the indirect effects of training on co-worker perceptions.

These findings are salient as diversity training has traditionally focused on knowledge-based approaches, and because it has been assumed that increasing awareness of differences will challenge the practitioner to question their own biases when making decisions. In contrast, these studies suggest that focusing on changing attitudes about diversity, emphasizing self-reflection, and developing transferable skills may be more important than increasing knowledge of differences (Kai, Spencer & Woodward, 2001).

Given the challenges and potential negative consequences of diversity training, some researchers have also argued for a shift in focus from the group to the individual so that participants are able to choose how they define themselves rather than being categorized according to their skin colour (Dogra & Vostanis, 2005). In addition, this will prevent practitioners in the mental health care profession from assuming that individuals from the same background have the same views on issues regarding mental health (Dogra & Vostanis, 2005). Bussena and Nemec (2006) recommend that training programs emphasize that there are no truly homogeneous racial groups, and that culture includes not only ethnicity, but geographic area of origin, primary language, age, sexual orientation, health status, and religious beliefs. The authors also stress that, in the mental health profession, training should focus on respect, willingness to work with individuals from diverse backgrounds, and awareness of the influence of the practitioner's own culture on service delivery and the therapeutic relationship. Furthermore, it has been suggested that ongoing discussion groups be incorporated into training, as they can help staff members understand how culture influences who a person is without determining who they become, and can also contribute to appreciation of variations in traditions, beliefs, history and worldview (Bussena & Nemec, 2006).

2. Components of Effective Programs

Several elements of effective programs have been outlined in the literature on diversity training. These include performing a needs assessment, garnering top-management support, and combining the training program with other diversity initiatives.

a. *Needs Assessment*

As there are many approaches and methods of delivering diversity training, several researchers have emphasized the importance of aligning programs to the needs of the organization (Delphin & Rowe, 2008; Siegel, Davis-Chambers, & Haugland, 2000; Sue, 2003). This can be accomplished by gathering information from front-line and administrative staff about past experiences with cultural competence training, and key areas that they want the workshop to cover. This process can help to tailor workshops to specific interest areas, inform the development of case examples and vignettes, and increase interest in participation (Delphin & Rowe, 2008). In order to perform a needs assessment, administrators and providers of mental heath organizations who plan the

services provided also need to acquire information on the characteristics of the population in treatment, the diverse cultural groups in the surrounding community, demographic information such as socioeconomic status, languages spoken, and literacy levels, service preferences of these groups, and cultural beliefs and practices of the community (Siegel et al., 2000). This strategy is currently being implemented by the Canadian Mental Health Association (CMHA) through the "diversity lens" framework. This framework consists of a checklist that can be used by all organizations to identify and reduce barriers to access, evaluate existing policies and procedures, and ensure that these policies are sensitive to the needs of diverse participants and staff. The checklist consists of criteria (i.e. access to information, visuals, language, recruitment, evaluation, programs and services) that can be used to evaluate the accessibility of information that is being offered to the community (refer to Canadian Mental Health Association, 2007 for detailed information). These assessments can then help to formulate strategies and design effective programs that meet the specific needs of the organization and community.

b. *Managerial Support*

Wentling and Palma-Rivas (1998) interviewed twelve diversity experts that were identified through an extensive review of the literature related to diversity in the workplace, and all acknowledged commitment and support from top management as an important component of effective diversity training programs. These experts stressed that management plays an important role in facilitating communication through the organization about the importance of diversity, why it is being offered, how the training is linked to the organization's goals, and in providing resources to support diversity training. Moreover, top executives set an example for their employees and display, through their actions, how important diversity is to them (Wentling & Palma-Rivas, 1998). In support of this proposition, Rynes and Rosen (1995) conducted a field survey of factors affecting the perceived adoption and perceived success of diversity training, and found that both were strongly associated with top management support for diversity (Rynes & Rosen, 1995). Further support is provided by Bullock's (1996) study, which evaluated an anti-bias education program for teachers and found that the course director's support and belief in the benefits of this education were important factors in a teacher's evaluation and adoption of the program and in the successful integration of the principles in the classroom. Furthermore, after taking this course, teachers indicated a need for additional support for staff training, school visitations, and seeking out additional resources. They also expressed an interest in using support groups as a way to learn about the anti-bias curriculum. For this to be possible, the director must play an integral role in making resources available, discussing ideas, making time for group discussions, funding trips to meetings and conferences, and allowing time for staff to visit and learn from other programs (Bullock, 1996).

c. *Combination with Other Diversity Initiatives*

It has been proposed that isolated instances of diversity training are less effective than programs that are part of a diversity management initiative, and that diversity training and cultural competence training should be linked with other aspects of service delivery such as leadership training, team building, and employee empowerment (Dogra & Karim, 2005; Dogra et al., 2007; Paluck, 2006; Wentling & Palma-Rivas, 1998). For example, Dogra and Vostanis (2007) interviewed child and mental health services staff about what

they thought about the provision of services to diverse populations and what their training needs might be, and all respondents felt that further training was necessary in order to be able to apply what they had learned (Dogra & Vostanis, 2007). There is also some evidence to suggest that one-time only workshops may not be effective in improving service delivery and client outcomes. For example, Quist and Law (2006) evaluated a three-hour cultural competence workshop for health care workers that involved a combination of didactic methods, self evaluation exercises, observation of effective and ineffective physician-patient interactions, and skill building through experiential teaching methods. This workshop combined knowledge and awareness learning with experiential learning and skill building, and was effective in significantly affecting cultural attitudes and beliefs, indicating that participants were more culturally aware. Most also viewed the workshop as valuable, appropriate and effective. However, there was less evidence to show that these improvements translated into better health care. It is possible that connecting this workshop with other programs would improve outcomes, or that benefits may be accrued over time; however, more long term-evaluations and studies comparing one-time only workshops with longer programs are needed in order to determine this.

In light of these findings which have questioned the effectiveness of one-time only diversity training workshops, the mental health care field is moving towards a more systemic approach to improve diversity awareness and accessibility of services (Family Service Association of Toronto, 2006; Gardner, 2006). Many organizations are adopting an anti-oppression framework, which focuses on increasing community involvement and making administrative changes in policies and procedures. These policies ensure that staff and volunteers are reflective of the community being served, and that discriminatory and oppressive behaviours are not tolerated (Family Service Association of Toronto, 2006). Systematic community participation is also a central aspect of the anti-oppression movement. This entails involving the community in all aspects of planning and budget processes, including identifying needs, allocating resources, and evaluating outcomes (Gardner, 2006). Currently, several Local Health Integration Networks (LHINs) have been established by the government of Ontario in order to support and plan for this initiative (Local Health Integration Network, 2008).

Anti-oppression training is also an integral part of the anti-oppression framework. This training is ongoing, and emphasizes that oppression can operate on multiple levels (i.e. through individuals beliefs and attitudes, institutional laws and policies, and cultural norms and practices), not just through individual acts. Furthermore, activities offered through anti-oppression training are sequenced from low to high risk levels of disclosure in order to decrease participant resistance (refer to City of Toronto, 1998-2007 for details).

3. Participant Characteristics

Literature suggests that the effectiveness of diversity training depends on the characteristics of the participants. For example, there is some controversy as to whether organizations should try to assemble groups of trainees that are demographically heterogeneous with respect to gender, race, and age or whether homogeneous training groups are more effective (Robertson et al., 2001; Paluck, 2006). Some argue that heterogeneity can promote sensitivity to differences through exposure to individuals from

other cultural groups, and can also improve the quality of discussion (Kirkland & Regan, 1997; in Robertson et al., 2001). However, others argue that heterogeneity reinforces prejudiced attitudes among trainees, and that individual participants will feel obligated to assume token roles as representatives of their race, gender or other group. They maintain that homogeneous groups allow for frank discussions about training content and reduce concerns over impression management or political correctness (VonBergen, Soper & Foster, 2002). These groups also avoid having to place minorities in the "hot seat" when educating the majority group (Robertson et al., 2001). Although few studies have investigated this issue, there is some research to suggest that the effect of heterogeneity on diversity training depends on the level of cultural competence of the trainees. For example, Robertson et al. (2001) found that trainees with prior experience with diversity training responded more positively to training groups that were homogeneous with respect to race and ethnicity. However, performance was the same for those without prior experience, regardless of group composition. This might be because those with more experience are at a stage where they would like to develop their skills rather than increase awareness. Therefore, homogeneous groups may offer them a safer environment to experiment in, and provide them with the security and confidence that they need in order to do this. (Robertson et al., 2001).

Individual differences in experience can also affect which methods of training are most effective. For example, Robertson et al., (2001) propose that trainees with little previous exposure to diversity issues are likely to be at early stages of cultural competence. For these individuals, activities which focus on cultural awareness may be most affective. Alternatively, those with more experience may be more likely to benefit from training programs that provide opportunities to generate and practice alternative strategies for managing diversity, such as behavioural modeling. (Robertson, Kulik & Pepper, 2001). Again, more research is needed in order to investigate this issue.

In addition to influencing the effectiveness of group composition and training method, pre-training competence levels also impact on an individual's likelihood in participating in diversity training. For example, Kulik, Pepper, Robertson & Parker (2007) found that trainees with higher pre-training competence levels were more likely to express an interest in further training and to attend a voluntary training session. As a result, those with the greatest need for training may be the least likely to participate in these programs. Given the link between low participation and low self-efficacy, the authors suggest that self-efficacy should be enhanced to encourage participation among these individuals. This can be done through early mastery experiences, and modeling, and by incorporating self-efficacy training into early mandatory training efforts to increase interest and evoke more positive reactions from employees (Kulik et al., 2007).

There is also some evidence to suggest that demographic characteristics of the population that the employees work with can affect the adoption and success of diversity training programs. For example, Bullock (1996) found that early childhood educators in rural settings, who worked with homogeneous populations that were predominantly Caucasian and Euro-American, struggled with the relevance of anti-bias training in their classrooms. These educators reported that, while issues of gender and disability were relevant and important to include in the classroom, some thought that focusing on diversity was irrelevant, and that all children were basically the same. They felt that it was difficult to

talk about people from other ethnic backgrounds when children in their classroom had not encountered children from other cultures before. Many educators and directors also did not clearly understand the goals and standards related to cultural diversity, and expressed beliefs that everyone in the classroom was alike, that children did not notice differences, and that bringing up differences could create prejudice (Bullock, 1996). This study indicates that staff members may be unaware of young children's early awareness of differences, and suggests the importance of incorporating this education in programs. Also, educators who demonstrated a lack of understanding of the goals of the program were found to be more likely to implement curriculum based on a "tourist" approach, which involved celebrating traditional holidays, incorporating themes such as "Children from Around the World" and using token approaches, such as having one doll, book or picture, to represent cultural diversity in the classroom. Therefore, it is also important that the goals, standards, benefits and importance of the program are made clear prior to training.

More positive anti-bias training outcomes have been reported by educators in urban settings with less homogeneous populations. For example, Mothercraft, in Toronto, is an organization committed to increasing diversity awareness, providing a welcoming and inclusive environment, and identifying best practice through research (Canadian Mothercraft Society, 2006). At Mothercraft, anti-bias content has been integrated into all aspects of early childhood education training, including home-based child care training, Early Childhood Education Assistant level training, and individual workshop sessions (Rhomberg, 2008). In order to investigate the effectiveness of this anti-bias curriculum, mailed surveys were delivered to Mothercraft alumni who had become in-service practitioners. This survey asked participants about the perceived influence of the anti-bias training they had received on service delivery to children and families, as well as the challenges they faced in delivering activities within an anti-bias framework. All in-service practitioners reported increased knowledge in the development of bias, and in their ability to deliver activities within the framework of anti-bias training. Participants also reported regularly evaluating decor, equipment, and toys for tokenism and exclusions. A majority of respondents also reported feeling comfortable intervening when racial comments, unfair behaviour, judgmental remarks, and stereotyping language were observed, and stated that they were able to apply the new skills that they had learned. Despite these positive effects, practitioners also experienced difficulty in accessing materials supportive of anti-bias concepts, insufficient encouragement and assistance from directors and co-workers, misunderstanding of why implementing anti-bias is important, and a lack of supportive anti-bias content in policies (Rhomberg, 2008). These findings indicate that anti-bias training can be very effective in diverse populations, when anti-bias content is incorporated into all aspects of service delivery, and when training is consistent with the organization's overall initiative. However, it is also apparent that, in addition to training, changes must be made at the administrative and policy level to facilitate and support the application of this knowledge.

4. Limitations and Future Directions

An important criticism of diversity training programs is that cultural competence focuses heavily on race and ethnicity, which takes away from other important issues such as gender, sexual orientation, and other-abledness (Stanhope, Solomon & Pernell-Arnold,

2005; VonBergen, Soper & Foster, 2002). For example, Dogra and Vostanis (2006) found that the diversity training participants in their study were critical of the assumption during training that race was the most important factor, and believed that this reinforced stereotypes. Furthermore, the majority of research about the impact of cultural competence on client outcomes also focuses on ethnicity and race, and the preference of clients for same-race providers (Vostanis, Abuyateya & Jewson, 2007). Recent studies indicate that children and youth have identified being treated with respect, being provided with accessible services that are visible to the community, and interacting with engaging staff as more important factors than interacting with a clinician of the same ethnic background (Dogra & Vostanis, 2007; Vostanis et al., 2007).

Anderson et al. (2007) posit that the dearth of research evaluating the effectiveness of cultural competence and diversity training programs can be explained by the difficulty in defining cultural competence, as it is a process and orientation, rather than a concrete and measurable construct. The process of becoming aware of one's own culture and how it influences personality and interactions with others is difficult to capture in a measurement scale (Stanhope et al., 2005). Moreover, the three domains of cultural competence outlined by the American Psychological Association (i.e. awareness, skills, and knowledge) have been questioned with respect to their reliability, and there is some concern as to whether or not these domains capture all aspects of cultural competence (Stanhope et al., 2005). A further limitation of the measures that are used to assess the effectiveness of training programs is that they have been developed without the input of clients and patients in recovery (Stanhope et al., 2005).

The literature on diversity training is limited by several additional factors. Most of the program evaluations that have been conducted have involved short-term evaluations which provide little information about the durability of the program. As benefits and consequences may unfold over time, long-term evaluations provide more in-depth information about changes in attitude and behaviour, and changes in the organization's overall cultural climate (Ivancevich & Gilbert, 2000). Follow-up information on short-term effects, strengths, weaknesses and impact of the diversity program can make change and improvement possible (Wentling & Palma-Rivas, 1998).

Another major weakness of the studies that have assessed cultural competence programs is the reliance on self-reported measures (Stanhope et al., 2005). Many of the studies which have evaluated diversity training programs measure participants' opinions of the training exercises and of their own perception of changes in attitudes and behaviours (Hite & McDonald, 2006). These measures are subject to bias as a result of social desirability and self presentation issues. Due to these biases, respondents may over or underestimate their cultural competence. For example, when completing measures before training, their responses may be reflecting what they anticipate to be their cultural competence after training rather than true baseline measures and attitudes, or they may find it difficult to measure their own cultural competence without having education about terms and concepts that are provided during training (Stanhope et al., 2005).

In addition to measuring participant satisfaction, there is a strong need to determine whether or not diversity training programs are associated with improved mental health outcomes among children and youth, and to evaluate behavioural changes and organizational or cultural changes that result from training (Hite & McDonald, 2006). In

illustration of this need, Anderson et al., (2003) conducted a systematic review of interventions to improve cultural competence in health care that included programs to recruit and maintain staff who reflect the cultural diversity of the community, use of interpreter services for those with limited English proficiency, cultural competence training for healthcare providers, and use of culturally appropriate health education materials. However, the effectiveness of these interventions could not be determined as there were too few empirically sound evaluations. Moreover, the studies did not examine the outcome measures included in the review, which included client satisfaction with care, improvements in health status, and use of services among minority populations (Anderson et al., 2003). Therefore, future research should use new methods to examine the effects of training on these variables. Siegel et al. (2000) recommend the use of information on access as an indication of the effectiveness of the diversity training initiative for service delivery. Examining utilization rates, cultural profiles of the population in treatment, service outcomes, and no-show rates can provide information about changes in service use as a result of the intervention. Consumer satisfaction can also be measured directly through surveys, observation of service environments, and lists of complaints that the agency has received (Anderson et al., 2007). New measurement tools to assess patient satisfaction are also being developed. For example, Lucas, Michalopoulou & Falzarano (2008) examine the factor structure, validity and other psychometric characteristics of a patient report measure to assess provider cultural competence, and their results support a three-part model of cultural competence which includes the patient's judgment of their physician's cultural knowledge, awareness, and skill. This new measure may address some of the limitations of cultural competence measurement, and may also lead to the development of standardized tools for use in future research (Lucas et al., 2008). In addition to these standardized measures, it has been recommended that clinical encounters be videotaped or audio taped and evaluated in order to determine whether diversity training initiatives have improved service delivery (Anderson et al., 2007).

A further limitation of the literature on cultural competence training is that most studies have not incorporated a control group as part of the evaluation. In order to determine whether changes are due to the training rather than other extraneous variables, an equivalent control group of non-participants is needed for comparison; however, very few studies have done this to date (Paluck, 2006).

Studies that evaluate cultural competence training programs are also subject to self selection bias. Those who participate in these programs may be more motivated to be culturally competent than those who do not participate, which can produce misleading findings. Therefore, future research should compare these individuals with those who discontinue training and those who do not participate (Stanhope et al., 2005).

Finally, many studies have investigated the general effectiveness of diversity training by interviewing participants with various organizational backgrounds (i.e. nursing, teaching, business, and mental health care) who have participated in different types of training. This makes it impossible to identify the specific educational methods and experiences that are most effective in changing behaviours and fostering culturally competent clinical care (Paluck, 2006). Future research needs to compare different approaches to diversity training to identify best practices. According to Ivancevich & Gilbert (2000), good

evaluations should identify important criteria for change targeted by the program, determine whether these criteria have changed, and whether these changes are the result of the diversity management training. It is also important to investigate whether these changes will occur in future replications of the program in the same organization, and different participants in other organizations (Ivancevich & Gilbert, 2000).

Researchers also need to spend time in organizations observing people, events, and interactions, rather than using mailed surveys, archival data, and secondary data base analyses that are typically used to evaluate diversity training programs. Furthermore, when carrying out evaluations, third party investigators are preferable to researchers conducting or consulting on the diversity programs because they provide a more impartial assessment of the training. These reports are more likely to carry weight with administrators, and to acknowledge unintended or unexpected results (Ivancevich & Gilbert, 2000).

Conclusion

Addressing diversity issues in the workplace requires a multi-method and systemic approach. As there is evidence to suggest that diversity training workshops have limited success, in and of themselves, it is imperative that further steps are taken in order to provide effective services to diverse populations. This can be done by incorporating various methods of training into programs and workshops, and by ensuring that employees are provided with the practical skills that they need in order to implement what they have learned (Anderson et al., 2007). Moreover, diversity training should be an ongoing process that is geared towards the needs of the community, and must be formulated and supported at the administrative level in order to produce changes in the organization's philosophy and overall cultural climate (Bullock, 1996).

This review has revealed large gaps in the literature concerning the evaluation of cultural competence and diversity training. Although many theories and models have been proposed, which serve as guidelines for training implementation, there is a paucity of research to investigate whether these models are useful and beneficial for the community members and participants for whom they were designed. In the future, it will be necessary to form collaborations between researchers, administrators and community members, and utilize innovative methods to assess the effects of training on service delivery and accessibility.

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