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Proactive anti-racism training for healthcare: study protocol for the development and evaluation of an Australian cognitive-behavioural therapy-informed racism reduction programme

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ABSTRACT

Introduction Racism in healthcare remains a barrier to health equity for Aboriginal and Torres Strait Islander people in Australia. This study protocol outlines the development and evaluation of a novel programme for racism reduction, drawing on aspects of cognitive behavioural therapy, motivational interviewing and the transtheoretical model of behaviour change. The project is led and governed by Aboriginal and Torres Strait Islander people and responds to the lived experience of Aboriginal and Torres Strait Islander people within the health system.

Methods and analysis An interactive educational programme has been developed, with seven modules designed to move people from 'precontemplation' through to identifying unhelpful beliefs and moving towards healthy relationships with themselves and others. An iterative developmental evaluation methodology will enable adaptation and improvement of the programme over three phases of implementation. Phase 1 will involve programme refinement and development of in-person and eLearning modules, informed by qualitative interviews with Aboriginal and Torres Strait Islander and non-Indigenous staff and students, and a cross-sectional survey of racist attitudes and beliefs among non-Indigenous people. In phase 2, an initial pilot to assess acceptability and feasibility will be carried out both in person (n=20) and online (n=30). Following further refinement, phase 3 will involve a larger pilot study with health professionals (n=50) and university students (n=50). The evaluation will incorporate pre-programme and postprogramme surveys and per-module evaluations, alongside qualitative interviews at key points during the project. The experiences of Aboriginal and Torres Strait Islander staff, patients and visitors will be monitored via an established patient experience measure (Yarn-Up Survey) already included in routine practice.

Ethics and dissemination The study has been approved by the Central Adelaide Local Health Network Human Research Ethics Committee (2024/HRE0057) and the Aboriginal Health Council of South Australia Aboriginal Health Research Ethics Committee (04–24-1130). Research dissemination will occur through presentations to stakeholders, academic journals and conference presentations. Refining the model at each phase will maximise its readiness for scalability across multiple health, medical education and potentially broader sectors in the future.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ Aboriginal governance and leadership are strengths of the study design, ensuring cultural relevance and applicability of the methodological approach.
⇒ The use of mixed methods combining qualitative narratives and quantitative outcome measures serves to mitigate the risk of sampling and participation bias.
⇒ A developmental evaluation approach enables continual refinement and improvement in response to feedback.
⇒ Future research would be strengthened by including longer term follow-up to assess whether programme impacts are sustained over the longer term.

INTRODUCTION

Racism is a serious public health problem that impacts on health both directly, via stress pathways, and indirectly by impeding access to quality healthcare. Being subjected to racism has been linked to a range of physical and mental health outcomes including poorer mental health, high blood pressure, increased levels of inflammatory and stress hormones and increased mortality (Australian Institute of Health and Welfare (AIHW), 2020). Physical effects of racism can present

across generations. Children who have experienced racism themselves, or vicariously via their caregivers, have elevated mental health problems, sleep problems, obesity and asthma, increasing risk for health problems later in life.[1] Chronic exposure to racism has been associated with lower birth weight, cognitive impairment, poorer sleep and higher levels of visceral fat, each of which increases vulnerability to a range of longer-term health problems of which there is a high prevalence in the Aboriginal and Torres Strait Islander population.[1–4]

Health systems reflect and perpetuate racial discrimination and inequities of the societies in which they operate. A meta-analysis of racism and health service utilisation found that racism experienced during healthcare reduces trust in healthcare systems and professionals, lowers satisfaction with health services and perceived quality of care and compromises communication and relationships with healthcare providers.[5] The review concluded that experiencing racism was associated with delayed care, reduced adherence and disengagement from follow-up services.[5] Poor health outcomes can stem from the direct effects of racism on mental and physical health, discriminatory provider decision-making resulting in sub-standard treatment and reduced engagement with services.[3 6–8]

Structural racism is maintained—in part—when individuals within systems are unable to recognise and challenge their own implicit biases and microaggressions or the biases inherent in the systems within which they work, even when they consciously hold antiracist attitudes.[9] Despite global efforts to acknowledge and reduce discrimination, for example, through the *United Nations Declaration on the Rights of Indigenous Peoples*,[10] and the efforts of Australian professional bodies and educators to embed cultural safety training in health provider training programmes,[11] Aboriginal and Torres Strait Islander people continue to report that incidents of racism are common, damaging and increasing.[12] Internalised racism occurs when individuals internalise (believe or adopt) negative beliefs about themselves that stem from the dominant culture.[13] This is arguably the most destructive form of racism. Conversely, *internalised domination* occurs when individuals within a dominant group incorporate and accept prejudices against others.[14]

Non-Indigenous people and systems that knowingly or unknowingly exert power need to change to eliminate racism. While policies are increasingly seeking to address racism,[15] there has been limited development of evidence-informed programmes that directly target racism within a health setting for the direct benefit of Aboriginal and Torres Strait Islander people. This, coupled with a paucity of evidence on the effectiveness of such programmes,[16] requires urgent attention. In an earlier review of the effectiveness of anti-racism strategies,[17] the authors reported that while limited, the available evidence suggests that an intervention is more likely to be effective when it is "… *multi-faceted, and developed in accordance with the specific and local circumstances of the community for which it is intended. Specifically, a dynamic, iterative and consultative approach, using both 'top-down' strategies … and 'bottom-up' strategies (eg, addressing specific racist behaviours), is more likely to succeed than are replications of 'one-size fits all' programmes…* "[17](p5). This suggests that antiracism interventions within healthcare settings should be tailored to the environment and directed at both individual and structural targets.[18] In the South Australian context, this individually focused antiracism intervention will complement existing structural interventions in local healthcare settings, such as the South Australian (SA) Government Antiracism Strategy, and health workforce registration competencies regarding cross-cultural safety.

The project aims to:

1. Refine a racism reduction programme informed by cognitive-behavioural therapy (CBT) for delivery to healthcare professionals and university students.
2. Pilot the programme in person and online.
3. Use developmental evaluation to improve the programme in real-time according to (1) its feasibility and (2) attitudinal changes and actions of non-Indigenous programme participants.
4. Monitor racism within the hospital setting from the perspectives of Aboriginal and Torres Strait Islander patients and visitors.

MATERIALS AND METHODS

Aboriginal and Torres Strait Islander governance and leadership is a key principle guiding this work. An Aboriginal and Torres Strait Islander Research Governance Group (RGG), comprising eight researchers, two hospital staff and two people who have experienced hospitalisation, all of whom are Aboriginal and/or Torres Strait Islander themselves, will oversee the 2year project including the continual refinement of the programme, evaluation, data analysis, results interpretation, reporting and future translation.

The programme

The programme is based on a model described in detail by Pedler *et al* (submitted). It comprises seven modules with content that draws on reflexive practice, Aboriginal perspectives and psychological theory including: CBT[19], the White Racial Identity Development Model first proposed by Helms,[20] the '3D Model',[21] the transtheoretical model[22] and motivational interviewing.[23] The seven programme modules are organised sessions that can be delivered either in person or online, as described in table 1. Within each module, a range of techniques are employed to facilitate better alignment between participants' values and their thoughts and behaviours related to privilege and racism. The programme includes homework tasks to consolidate and generalise in-session learning.

Study design

A mixed methods developmental evaluation approach will enable refinement of the programme in real time, over three phases of implementation. Developmental

Table 1 Content covered in each module

Module	Content
1. Embarking	*Definitions of racism and antiracism* *Experiences, prevalence and effects of racism* *Values and existing skills in reconciling violations of values and repairing relationship ruptures* *Emotional regulation skills and supports* *Positionality, values and change reflections*
2. Inheritance baggage	*The systemic basis of racism* *The impacts of systemic racism* *Anti-racism and values alignment* *Anti-racist role models*
3. The privilege bubble	*Racial privilege* *Thoughts, feelings and behaviour related to racial privilege* *Lived experiences of racism reduction* *Costs and benefits of racial privilege* *Experiences of change and values-based goal setting*
4. Bursting the bubble	*Cognitive dissonance when racism is observed* *Thoughts, feelings and behaviour related to dissonance* *Costs and benefits of dissonance* *Emotional regulation strategies* *Values, goals and change reflections*
5. Escaping discomfort	*Unhealthy coping responses to recognising racism* *Thoughts, feelings and behaviour related to unhealthy coping* *Costs and benefits of unhealthy coping responses* *Thought record and challenging unhealthy coping responses* *Values, goals and change reflections*
6. Exploring new horizons	*Experiences of overcoming challenge* *Thoughts, feelings and behaviour related to balanced thinking* *Costs and benefits of balanced thinking* *Thought record and balanced thinking* *Behavioural experiments and cross-cultural immersion* *Setback recovery*
7. Looking after each other and our place	*Learning reflection* *Relationship repair* *Costs and benefits of anti-racism* *Cross-cultural learning—social and emotional well-being* *Disrupting racism* *Encouraging anti-racism in others and goal setting*

evaluation allows for the inclusion of numerous data sources to continually refine the programme. Attitude and behaviour change will be assessed with a pre-programme and postprogramme questionnaire. Interviews with

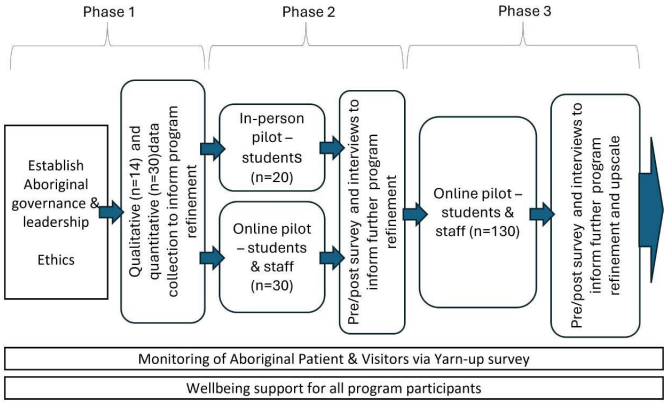

Figure 1 Programme refinement, piloting and evaluation.

programme facilitators and participants will inform development between implementation phases. Participants in the online programme will provide reflections on their experiences, enabling real-time feedback. All programme content will be reviewed by the Aboriginal RGG and investigator team prior to implementation, in monthly meetings convened for this purpose.

Setting

There are two proposed settings for programme implementation: two major tertiary hospitals and university faculty of medicine and health sciences.

Participants

Staff or students aged 18 years or older, who are employed in the Central Adelaide Local Health Network, or enrolled in health-related disciplines at Adelaide University in South Australia will be eligible to participate in this research. While the inclusion of university students will not directly impact the delivery of healthcare services in the short term, their participation in the anti-racism training is considered important for understanding the optimal setting for delivery, with a view towards influencing future practice.

Participants will be recruited via organisational email lists, community engagement, advertising posters, social media and digital notice board posts. Senior staff in hospital departments and university departments will be approached to champion the programme. Experiences of racism of Aboriginal and Torres Strait Islander staff, patients and visitors will be measured to inform the programme development and evaluation (see below).

Phase one: programme refinement

The module content within the Proactive Antiracism Training for Healthcare (PATH) manual will be refined and adapted for online and in-person delivery. Within the hospital setting, online delivery is required to enable the training to be accessed around staff rosters. In the university context, both online and in-person delivery will support flexible learning modalities for students. MoodleCloud (http://moodlecloud.com) is an open-source online learning management system that will be used

to present the content so the research team can easily develop and update the content after each phase.

Programme refinement will be informed by a cross-sectional survey of non-Indigenous undergraduate and postgraduate students (n=30) and hospital staff (n=30) adapted from established scales, for example, the Multicultural Competence Stage of Change Scale[24] and Wathaara Scale (previously Ganngaleh nga Yagaleh Tool (25-items)),[25] developed specifically for the evaluation of cultural safety programmes. Participants will be invited to complete the survey online via REDCap.[26] Descriptive statistics will be used to summarise survey responses and examine patterns in participants' reported attitudes, beliefs and understandings of racism.

Qualitative interviews with non-Indigenous medical, nursing, allied health and administrative staff (n=8) will explore perspectives on and understandings of racism, key issues they identify in their work and ideas for addressing racism. Aboriginal and Torres Strait Islander staff and students (n=8) will be interviewed to ensure the programme incorporates key issues of concern for them. Interview guides are included as online supplemental information. Interview participants will receive a $A50 gift voucher for their time. Thematic analysis[27] will be used to explore how racism is understood and experienced by participants, and how they consider it could be addressed interpersonally and within the health system.

In line with the programme's ultimate aim of improving the experiences of Aboriginal and Torres Strait Islander people accessing healthcare, throughout the project, racism will be monitored within the hospital from the perspective of Aboriginal and Torres Strait Islander patients and visitors via a survey of patient experiences informed by earlier work by Elvidge *et al*.[28] The 'Yarn-Up' Survey is available to all Aboriginal and Torres Strait Islander patients and visitors to the hospitals via a Quick Response (QR) code displayed on posters and electronic screens next to hospital beds. Patient advocates are available to assist with survey completion when required. Data summaries will be provided to the research team by the Central Adelaide Local Health Network (CALHN) data custodians.

It is unlikely that changes in experiences of racism over time will be detectable given the relatively small scale of the pilot and short time frame, but these data will be considered by the research team and Aboriginal RGG, along with the other survey and qualitative data, to inform programme development and adjustment. For example, findings may point towards the utility of including particular examples of racism, case scenarios, written content or resources that address identified experiences or gaps in knowledge. The Yarn Up Survey will continue beyond the life of this project, enabling longer-term monitoring of racism.

Phase two: initial in-person and online pilot

The subsequent 3 months will involve acceptability and feasibility testing of the programme and proposed measures. The team will invite hospital staff (n=10 online) and students entering training for healthcare occupations (medicine, nursing, allied health: n=20 online, n=20 in person) to complete the training (total n=50) and provide detailed feedback, which will be considered for incorporation into the programme as appropriate. In-person training will be delivered in groups of 10 by two facilitators for each group. Given the sensitivity of the content and the novelty of the approach, all participants will receive a phone call from a registered psychologist at least twice during the training to conduct a confidential 'well-being check', with additional checks available on request.

All participants (n=50) will complete preprogramme and postprogramme evaluation surveys adapted from the Stages of Change[23 24] and Wathaara[25] tools, administered via REDCap.[29] Survey links will be emailed directly to participants in the week prior to commencing the programme and directly following completion, with a request to complete the postprogramme survey within 1 week. Data will be analysed in accordance with Caban,[22] with preprogramme and postprogramme scores compared for each 'stage of change'. Summary scores on the Wathaara tool will be compared using a paired samples t-test. Assumptions of normality will be assessed prior to analysis.

In addition, after each module, we will ask questions that evaluate satisfaction with each component, mode of delivery, length of programme, suggestions for improvement and any changes to practice participants have made or intend to make that they attribute to the training. At the completion of the programme, 15 participants (hospital staff, n=5; students online, n=5; students in person, n=5) will be contacted for a brief interview to explore their experience and discuss their reflections, as well as barriers and facilitators to engagement and changes (if any) they intend to make as a result of the training. In-person facilitators will keep journal reflections on course delivery (including fidelity) and participant perceptions. Any departure from the original design will be explored with staff delivering the intervention, the RGG and the investigator team as part of reflective practice approaches. In line with a developmental evaluation approach, assessing the appropriateness of any suggested changes to programme content, whether delivered online or in person, will include consideration of fidelity, with a view to ensuring that any changes support the original intent and mechanisms of the original programme model. All changes will be documented and reported as part of the evaluation.

Phase three: broader implementation and follow-up data collection

The final 6 months of the project will involve broader implementation of the refined content and collection of follow-up data. Online training will be made available to the first 50 staff within hospital departments with high Aboriginal and Torres Strait Islander attendance and the first 50 university students studying in health-related

fields who express interest. All staff in identified wards will be invited (eg, Integrated Care Program, Mental Health Clinical Program and Cancer Program) with a purposeful approach to recruit across administration and all clinical disciplines. Telephone contact with a psychologist will be available to participants on request. Staff will also have access to employee assistance programmes and students will have access to the university's counselling service. All participants will have access to a registered psychologist should they require support.

As in phase 2, all participants will complete the pre-programme and postprogramme survey and per-module evaluations. A purposeful subset of diverse participants (hospital staff, n=15; students, n=15) will be invited to participate in an interview to explore experiences of the training, including lessons learnt, acceptability of content and changes implemented personally or professionally because of the training. Acknowledging that some participants may not complete the programme, we will endeavour to speak with both those who complete all the modules and those who may withdraw before the final module to understand reasons for drop-out.

Ethics and dissemination

Ethics approval has been granted by the Aboriginal Health Council of South Australia Aboriginal Health Research Ethics Committee (04–23-1130), and the CALHN Human Research Ethics Committee (2024/HRE00057). Informed consent will be obtained from all participants prior to participating in all aspects of the study. Research dissemination will occur through publications in community reports, academic journals and conference presentations, as well as presentations to stakeholders such as the State Government Department of Health (SA Health), heads of hospital departments and Aboriginal and Torres Strait Islander well-being support services. Information collected for this project will be kept strictly confidential. All data pertaining to this study will be non-identifiable. This study will generate vital evidence on a Cognitive Behavioural Therapy Informed Racism Reduction Program and its feasibility and acceptability within health and university settings. As far as we are aware, this study represents the first attempt to tailor a Cognitive Behavioural Racism Reduction Program in the Australian health system context. The developmental evaluation provides opportunities for continual refinement of the model, ensuring its readiness for implementation and scalability across multiple health, medical education and potentially broader sectors in the future.

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Contributors RR, OP, KM, MP and KK led the conceptual development of the study. All authors oversaw methodological decisions. LH, NK, TL, ML and SL coordinated planning of data collection and recruitment across partner sites. AC-H, YC, TB and KD'O have contributed specialist expertise to guide study design and analytic approaches. JL and LT contributed to community engagement. All authors contributed to the refinement of the manuscript, approved the final version and agreed to be accountable for the accuracy and integrity of the work. Guarantor is OP.

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