Article

Diversity training for health professionals: Preparedness to competently address intellectual disability in the Western Cape Province, South Africa

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Abstract

Diversity training for health professionals in South Africa has traditionally been conceptualized as differences in gender, race or ethnicity, culture and sexual orientation. More recently physical disability and mental illness was included as a dimension. Intellectual disabilities received lip service as a diversity concern. This paper reports on health professionals' perceptions of the extent to which diversity training prepared them to competently deal with intellectual disabilities. This explorative study included a purposive sample of 18 health care professionals experienced in intellectual disability services. Two focus groups were facilitated over three sessions. Transcripts were analysed thematically. Health professionals felt inadequately prepared to consider intellectual disabilities as a diversity issue. They could not effectively advocate for reasonable accommodation. There was a differential familiarity with issues related to diversity and intellectual disability with profession constituting an additional intersecting dimension of diversity. Health professions did not perceive their diversity training to prepare them to deal competently with intellectual disabilities.

Introduction

The Health Professions Council of South Africa (HPCSA) requires that professional programmes include diversity training and multicultural competence in their curricula (HPCSA, 2019). The operationalization of diversity training in the health professions education is at the discretion of the

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programmes and training departments. There is great variation in the intensity, focus and comprehensiveness of diversity training ranging from occasional seminars to modules that address contextual issues including diversity (Phillips et al., 2016). Despite the variation in the scope of training, all health professionals are expected to demonstrate competence in multiculturalism and diversity (Alhejji et al., 2016). The expectation that health professionals must be competent to deal with issues of diversity is evidenced by the inclusion of acts and policies related to the rights of people with disabilities in the board examinations for all practitioners who wish to register with the HPCSA (Department of Justice and Constitutional development, 2014).

The literature on diversity training for health professionals identified four core recommendations. Novak et al. (2004) recommended that exposure to diversity training is helpful and necessary to prepare health professionals for the workplace. Anderson et al. (2009) suggested that educators and administrators require appropriate training and support play an important role to develop curricula that produce professionals who are competent in dealing with diversity. Victoroff, Williams and Lalumandier (2013) recommended that students' day-to-day experiences with a diverse patient population must be considered. Kai et al. (1999) suggested that the examination of students' own attitudes and appreciation of structural influences on health and health care (such as racism and socio-economic disadvantage) should be promoted. Learning must also be explicitly linked to assessment and professional accreditation.

Diversity training for health professionals in South Africa, has focused primarily on traditional conceptualisations of difference based on culture, race or ethnicity, socio-economic status and sexual orientation (Jirwe et al., 2009; Roberts et al., 2005). Fernando and Moodley (2018) cautioned that diversity training should not be narrowly focused on cultural differences alone. Moodley and Barnes (2014) recommended that an expanded understanding of diversity must be adopted that includes stigmatised social identities of gender, race, sexual orientation, class, age, religion, physical disability and mental illness. Diversity training related to mental illness focused on reasonable accommodation for debilitating clinical diagnoses such as Bipolar Disorder, and disruptive disorders such as Attention Deficit disorder (ADD/ADHD). Intellectual disability and cognitive impairment has not been a focus of diversity training (Alhejji et al., 2016).

Intellectual disability includes significantly sub-average general intellectual functioning (having an IQ of 70 or less) and impairment in adaptive functioning manifested before the age of 18, according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) (American Psychiatric Association (APA), 2013). Adaptive functioning is typically assessed in terms of communicative abilities, the ability to perform activities of daily living, and socialization (Smith, 2010). Maulik et al. (2011) reported that the prevalence of Intellectual disabilities across the world is 1% (10.37/1000). The prevalence for Intellectual disability in South Africa remains unconfirmed. Adnams (2010) stated that an accurate description of the prevailing epidemiology and burden of disablement in South Africa is difficult due to the lack of evidence-based publications. The South African Federation of Mental Health (SAFMH) suggests that intellectual disability is more common and estimates that four out of every 100 South Africans are affected by some level of intellectual impairment (SAMFH, 2019). Adnams (2010) identified the range of Intellectual disabilities in South Africa between 0.27 and 3.6% of the population based on several studies. Thus, the distribution of intellectual disability geographically, across population groups and age groups is not known, which makes it difficult to identify inequalities and differences in the distribution. McKenzie, McConkey and Adnams (2013) reported that intellectual disabilities has a relatively high incidence in the Western Cape of South Africa with increased risks for poor health outcomes. Thus, it is important to study issues associated with intellectual disability (e.g. service delivery) at a provincial level.

The severity of intellectual impairment is classified as mild (IQ 55-70), moderate (IQ 35-54), severe (IQ 20-34) or profound (IQ below 20) (APA, 2013). The categories of intellectual disability have differential adaptive and intellectual capabilities (Morano, 2001). For example, in South Africa, those diagnosed with mild intellectual disability are able to receive schooling up to the sixth-grade level and vocational training that enables them to work and live in the community with minimal supervision. Thus, people with intellectual disabilities require services such as, protective employment or reasonable accommodation in a more open market (Morano, 2001). The information gap in the epidemiology and burden of disability further compromises the training and subsequent ability of health practitioners in the South African context to plan for and meet the needs of those with intellectual disabilities across their lifespan.

In South Africa, services to people with intellectual disabilities are offered across three levels. At the primary health care level, services are offered through non-profit organizations (NPOs) and Community health clinics based in the community where the people with intellectual disabilities reside. The services offered includes outpatient services, social support services (e.g. disability grants) and indirect services such as advocacy. At the secondary level, people with intellectual disabilities may attend day care programmes based in the community, will stay in residential facilities subsidized by the government and will be able to visit hospitals for general medical comorbid presentations. This level also includes the provision of protective workshops and remedial or learning support to people with intellectual disabilities. At the tertiary level, inpatient partial and full hospitalisation is offered at dedicated hospital based intellectual disability units including diagnostic admissions, therapeutic admissions and respite admissions to lessen the burden on caregivers. Adnams (2010) further identified that a small percentage of health practitioners are engaged in service delivery or research in intellectual disability. Indirect services such as advocacy, are not optimally prioritized despite the high burden of preventable causes of intellectual disability in South Africa (Smith, 2010). Stein, Sordsdahl and Lund (2018) underscored that services for people with intellectual disabilities continue to lag behind.

In South Africa, health professionals are mandated to provide comprehensive services including advocating for and facilitating the reasonable accommodation of people who are differently abled (SAMFH, 2019). South Africa subscribes to the United Nations Convention on the Rights of Persons with Disabilities (SAMFH, 2019). Subsequently, several policy documents provide a statutory mandate for health professionals to counter exclusionary and discriminatory practices for minority and vulnerable groups such as people with disabilities including the Bill of Rights (1996), Chapter Two of the Constitution of South Africa (Government Gazette, 1996 No. 378; Government Gazette 1996 No. 17678), Mental Health Care Act (MHCA, 2002) and the National Mental Health Policy Framework and Strategic Plan 2013–2020 (National Department of Health, 2012). Other policies and documents that have direct bearing on disability include the White paper on the rights of persons with disabilities (Kamga, 2016), the National Disability Rights Policy (Department of Social Development, 2016) and the Policy framework on services to persons with intellectual disabilities (Western Cape Government, 2015). Despite the existence of transformational policies, and frameworks for services to people with intellectual disabilities in South Africa, recognition of and provision for their needs remains a low priority (Adnams, 2010). People with intellectual disabilities experience compounded challenges in the acquisition of rights entitled by the South African constitution (Capri et al., 2018). The extent to which diversity training equip health providers with competencies to provide comprehensive services, conduct research and influence policy that can realize the intentions of the Constitution and subsidiary policy documents for this vulnerable group, has not been interrogated.

Problem statement

Persons with intellectual disabilities are educable and can receive vocational training. However, their challenges in the cognitive and adaptive functioning realm, regardless of the extent of the impairment, increase their vulnerability for exploitation on numerous levels (SAMFH, 2019). In keeping with the National Development Plan 2030, the Health Plan 2030 (South African Government, 2013), and the Constitution of South Africa (1996) as primary governance documents, individuals with intellectual disabilities require accommodations that will address the barriers to active citizenry and the development of their potential relative to their level of disability or impairment (Capri et al., 2018). The health plan also requires professionals to be competent and committed to addressing clinical issues and the vast array of sociocultural determinants that come into play in the facilitation of active citizenship. This has major implications for the higher education institutions that provide training for health professionals. Higher Education South Africa (HESA) responded to the National Development plan and the National Health plan 2030 by stating that higher education must fulfill three key functions to help develop a nation: (1) provide people with indispensable high level skills; (2) be a dominant producer of new knowledge and (3) provide opportunities for social mobility (National Planning Commission (The Presidency) (NPC), 2011). Thus, institutions of higher education are tasked to produce competent and highly skilled health professionals that can address the challenges through knowledge production and promote social change. Health professionals in turn are tasked with the assessment and treatment of, and advocacy for vulnerable groups, such as people with intellectual disabilities. However, training for health professionals disproportionately focuses on clinical aspects and there has been anecdotal evidence that training of health professionals does not adequately prepare clinicians to deal with issues of diversity, as required and outlined by the policy documents (SAMFH, 2019). Thus, there is a need to explore the extent to which diversity training prepares health professionals for engaging competently in service delivery to people with intellectual disabilities.

Method

Aim

The aim of this paper is to report on the extent to which health professionals perceived diversity training to have prepared them to competently deal with intellectual disabilities.

Methods

The study was exploratory in nature as it attempted to gain new insights about the perceptions of health professionals about the extent to which their training prepared them to competently deal with diversity issues related to intellectual disabilities. A purposive sample of 18 health care professionals experienced in intellectual disability services in the Western Cape region was recruited. Qualitative methods of data collection and analysis were adopted in keeping with the exploratory nature of the study (Merriam, 2009). Two focus groups of nine participants each were facilitated. Groups were facilitated over three sessions to deepen the richness and complexity of the discussions (Barbour, 2007). In the initial group participants were asked to reflect on their training in diversity. In the second group participants were asked to reflect on managing intellectual disabilities. In the third, participants were asked about the extent to which they perceived their training prepared them to deal with diversity issues related to intellectual disabilities.

Data collection

Two field workers, experienced in facilitation and clinical work, facilitated the focus groups and tracked both content and process. Immediately after the discussions, a brief summary of the core content of the group was provided to the participants for validation (Krueger and Casey, 2000). At the beginning of the second and third sessions, a summary of the preceding session provided a second opportunity to validate the researcher's understanding, as well as to provide linkages between group sessions. In this way more nuanced exploration was achieved that produced more credible data consistent with the recommendation of Puchta and Potter (2004).

Analysis

Transcripts were subjected to a thematic analysis following the steps outlined by Creswell (2014). Two reviewers conducted the analysis to increase the trustworthiness of the data and consensus was reached through discussion. The primary researcher was a clinical psychologist who was familiar with the contexts in which participants worked and the training context which contributed to a deeper discussion.

Results

Health care professionals experienced in intellectual disability from six professions were included in the sample. Table 1 reflects the demographic profile of the sample.

From the thematic analysis, six core themes emerged with sub-themes.

Table 1. Demographic profile.

Participant	Group	Registration	Age	Gender	Race	Years of registration	Years in IDS
1	1	Medical officer	32	Female	White	6	3
2	1	Occupational therapist	27	Female	White	4	2
3	2	Occupational therapist	24	Female	Coloured	2	1
4	2	Physiotherapist	25	Female	White	1	4 months
5	1	Psychiatric nurse	55	Female	Indian	17	9
6	1	Psychiatric nurse	43	Female	Coloured	9	4
7	2	Psychiatric nurse	41	Female	Coloured	7	3
8	2	Psychiatric nurse	50	Male	Black	18	16
9	1	Psychiatrist	48	Male	Coloured	8	4
10	2	Psychiatric registrar	27	Female	Indian	1	6 months
11	1	Psychiatric registrar	32	Male	White	3	1
12	1	Psychologist	37	Female	Coloured	5	2
13	2	Intern psychologist	29	Female	Coloured	1	1
14	1	Social worker	45	Female	Coloured	15	3
15	2	Social worker	37	Female	Coloured	11	6
16	1	Social worker	29	Female	Black	8	1
17	2	Social worker	43	Female	Coloured	12	7
18	2	Psychologist	25	Male	White	1	3 months

Theme 1: Intellectual disability as a clinical issue

All the participants struggled to identify intellectual disability as a diversity issue and agreed that intellectual disability is a clinical issue. Three sub-themes emerged that further illustrated the default position of health professionals. Table 2 below presents the sub-themes with illustrative quotes.

Sub-theme 1: Otherness and differential ability in cognitive capacity. As clinicians, the participants returned to the question whether differently-abled individuals have the cognitive capacity to recognise and engage in otherness. No consensus could be reached on this question. The level of discussion generated clearly illustrated that this posed a challenge for the practitioners. The discussions in the follow-up groups became more intellectual and did not translate into practical considerations or implications.

Sub-theme 2: Concrete versus abstract thinking. This sub-theme is linked to the clinical reality that individuals with intellectual disabilities are by definition more prone to concrete reasoning and thinking. This becomes a major difficulty that affect their adaptive functioning, treatment and the extent to which others can provide personal or professional care. The participants reflected that this feature of intellectual disabilities makes it very difficult, if not impossible, for affected persons to think reflexively about ways in which they are different and by extension could access or require differential treatment or reasonable accommodation.

Table 2. Theme 1- Intellectual disability as a clinical issue.

Sub-theme	Illustrative quotes
1 Otherness and differential ability in cognitive capacity	'Patients with intellectual disability differ in the severity of their limitation, but they certainly not able to track the subtleties of real diversity e.g. race and gender' (g1, p3)
	'But can they really … I mean are they capable of such finer distinctions and inference and innuendoes' (g1, p7)
	'Borderline intellectually disabled people get raped 'cos they can't identify suggestion and read between the lines. How are they ever going to grasp subtleties. You know how tricky diversity issues become even for us high functioning lot' (g2, p4)
2 Concrete versus abstract thinking	'On the ward, all I see is how terribly concrete they are. They struggle with anything that requires higher levels of cognitive functioning' (g2, p1)
	'The very diagnosis speaks to compromised brain function. I know such patients tend to be very literal and gullible most times' (g2, p9)
	'It is what it is. I mean clinically it was even called mental retardation. So they are not going to be all sensitive to diversity issues based on their diagnosis. Like bipolars or schizophrenics have higher levels of cognitive functioning, so a paranoid schizo can be aware of being discriminated against. But intellectual disability patients won't even register it (gestures with hand) it's like way over their head.' (g1, p3)
3 Interaction between levels of intellectual disability	'mild, moderate, severe, profound. They all can do different things. Mild can even be trained. We must all work with the categories so that we know what treatments to plan for their level.' (g1, p5)
	'Us clinicians must be familiar with how the categories differ so we can tailor our services. So you can't do insight therapy with the severely disabled.' (g1, p2)
	'The categories are so … discrete. The more brain damage there is the less adaptive the person is and vice versa.' (g1, p1)

Sub-theme 3: Interaction between levels of intellectual disability. All participants were willing to concede that there is an interaction between levels of intellectual disability. People diagnosed with various levels present with differential capabilities in adaptive functioning and cognitive ability. However, the diagnosis of intellectual disability presuppose a deficit in cognitive functioning that limits and or precludes reflexivity and abstract thinking. This clinical symptom or feature is a deciding factor in diagnosing intellectual disability.

Theme 2: Clinical constructions of the intellectually disabled

The participants indicated that they primarily construct the population of people with intellectual disabilities in clinical terms. This construction becomes their dominant frame of reference with major implications for the conceptualization of service delivery and professional responsibilities towards this vulnerable population. Table 3 below reflects the sub-themes with illustrative quotes.

Subtheme 1: Aetiology and the subject position of practitioners. Practitioners expressed that the aetiology of intellectual disability is organic, even when resulting from traumatic brain injury. The resultant damage to brain tissue and the genetic abnormalities in congenital cases point to identifiable organic deficits in brain functioning. Thus, the stance adopted towards people with intellectual disabilities is clinical in nature.

Subtheme 2: Ethics of care. Participants indicated that their default clinical understanding of intellectual disability informed the ethics of care in health care that was adopted in service delivery. Participants reflected that people with intellectual disabilities needed to be looked after that reflects an ethic of custodial care. Custodial care relates to the imperative to ensure that people with disability are kept safe and are "looked after" regardless of where they are accessing health services for clinical management. Participants also reflected that service delivery for people with intellectual disabilities included an ethic of clinical care. Clinical care deals more with the management of clinical presentations, especially comorbidity. Thus, caretaking and clinical care became the priority when delivering services to this population.

Table 3. Theme 2- Clinical constructions of the intellectually disabled.

Sub-theme	Illustrative quotes
1 Aetiology and the subject position of practitioners	'It is caused by damage, damage to the brain. Like maybe anoxia or a TBI (traumatic brain injury)…So the brain or organ doesn't work' (g2, p10) 'I am a doctor and I have to see them as patients with brains that don't work properly.' (g1, p1) 'So I have to think 'what is wrong with this patient' and then I can case manage.' (g2, p17)
2 Ethic of care	'It's like I can't do therapy. Only make sure that they have grants, a place to live and so on.' (g1, p14) 'They take looking after like children. I don't mean to be offensive but they, struggle to be more independent and engage more.' (g2, p10) 'It's very different working with this group than any other patients. Even the psychotics settle down and then they like more normal, but here, here you just taking care of them.' (g2, p6)

Theme 3: Preparatory training

Participants agreed that their professional training did not adequately prepare them to work with the range of issues that they confront in this population. Participants reflected that the training they received singularly focused on diagnosis and clinical management. Table 4 below reflects the sub-themes with illustrative quotes.

Sub-theme 1: Clinical foci (diagnostic and management). Participants indicated that their baseline training focused on clinical aspects such as diagnosis and management. For more medically-based professions, there was greater emphasis on the organic aetiology and the clinical manifestations of damage to specific regions of the brain. For more rehabilitative professions there was a focus on skills development and normative development to facilitate the management of functional impairments. For more socially-oriented professions the focus was on therapeutic techniques, such as behavior modification, and adaptive functioning such as basic activities of daily living. Participants reflected that the theoretical component of their degree programmes was not adequate for dealing with the complexity of clinical issues, and was insufficient for dealing with non-clinical aspects of intellectual disability.

Sub-theme 2: Direct and indirect services. Participants made a distinction between direct and indirect services. Direct services included diagnosis, treatment etc. Indirect services included advocacy, policy formation and psycho-education. Participants reflected that in general, direct services were prioritised above indirect services. Service delivery for people with disabilities focused on direct services at the expense of indirect services.

Subtheme 3: Desensitization. Participants reflected that their training on diversity specifically focused on issues of gender, race, sexual orientation and socio-economic status. The inputs were

Table 4. Theme 3- Preparatory training.

Sub-theme	Illustrative quotes
1 Clinical foci	'The little training we did get was all about diagnosis and testing and how to tease out comorbidity.' (g2, p11)
	'So I knew how to assess and what the criteria were, but seeing intellectual disability in real life … there was so much more than psychology prepared me for.' (g2, p18)
	'It's all about what they can and cannot do cognitively, and like toileting and tying shoes and dressing yourself. The OTs (occupational therapists) call it ADLs (activities of daily living).' (g2, p7)
2 Direct and indirect services	'We practiced medicine and adherence.' (g1, p11)
	'For us too it was like testing and therapy. Although we know about psycho-education that was not what the training focused on.' (g2, p13)
	'The services we were trained to provide were very traditional and focused on the individual patient and to a lesser extent On the family and so on.' (g1, p12)
3 Interaction between levels of intellectual disability	'We had to attend these silly talks and workshops on diversity and gender and race and blah blah blah. It was so frustrating because it took away time from learning about real disorders.' (g1, p6)
	'After a while it was like, here we go again … gender and race.' (g1, p9)
	'It was like a free period, like nobody took it seriously after a while.' (g1, p14)

stereotypical and did not promote engagement, interest or reflexive practice. The intellectually disabled were a vulnerable clinical group that they could not reconcile with the stereotypical images of 'diversity.'

Theme 4: Experiential learning

Participants all reflected that the "real learning" about intellectual disability took place experientially. Rotations through clinical placements for dedicated services to people with intellectual disabilities within hospital settings, were more successful in broadening the training. Participants reflected that such service learning prepared them to deal with the challenges faced by this vulnerable group. However, the existing rotations were rooted in the medical model and further entrenched the clinical constructions mentioned above. Table 5 below reflects the sub-themes with illustrative quotes.

Sub-theme 1: Service learning. Participants agreed that they would not have chosen to work in the field of intellectual disabilities if they were not exposed through service learning rotations. Immersion into placements that provided dedicated services to people with intellectual disabilities

Table 5. Theme 4- Experiential learning.

Sub-theme	Illustrative quotes
1 Service learning	'When I was first placed in intellectual disability services I was very upset, but now I am grateful since I discovered a passion and a place where I feel like I make a difference.' (g2, p7)
	'I remember memorizing all those criteria and differentials for intellectual disability with great difficulty. Then I walked onto ward X and it all came alive. Now that I have seen it first hand, I will never forget it. So much more useful than studying theory.' (g1, p1)
	'So we joked that we were just free student labour, but the greatest gift is what the patients gave us by allowing us into their experience and struggle. It was so humbling … a real privilege.' (g1, p2)
2 Personal experience	'So my brother's girlfriend has an intellectually disabled child and it made me more understanding of the needs etc.' (g2, p3)
	I wanted to help others who were like my brother. This can be my life's work.' (g1, p12)
	'My cousin died in hospital. He was intellectually disabled and they missed other medical problems assuming that he was simply struggling due to impaired intellectual functioning. Nobody should be treated this way, and so I became a doctor and then a psychiatric registrar.' (g1, p11)
3 Disadvantages to experiential learning as modality	'I wasn't prepared for what I saw on the unit during that first rotation. I was so unprepared and couldn't find anything in my notes and training on how to deal with the complexity and extent of the presentations.' (g2, p18)
	'There was just so much to do. I couldn't think straight and ended up hating intellectual disability" (g2, p10) "some of us felt like we weren't learning so much as learning what not to do and where we didn't want to work.' (g1, p5)

facilitated learning in a practical context and provided reality-based references. This enabled the participants to develop a realistic understanding of the nature of the work and the challenges faced by staff and patients.

Sub-theme 2: Personal experience. Four participants disclosed that they had a family member or close friend diagnosed with intellectual disability. Their personal references and engagement with the diagnosis and the deficits in health care systems compelled them to pursue clinical training and to work in the area of intellectual disabilities. These personal experiences resulted in passionate decision-making about work after graduation before training even commenced. This, in part then, also reflected on their experience of the training as inadequate since they were expecting a more comprehensive input.

Sub-theme 3: Disadvantages to experiential learning as modality. Participants identified in the second and third focus groups that there were challenges associated with service learning as well. Two distinct challenges emerged. Firstly, exposure to critical theory was limited in experiential learning since the focus was on hands-on clinical training. Secondly, the emotionally and clinically demanding nature of under-resourced clinical placements seldom afforded the opportunity for reflection.

Theme 5: Professional identities

Participants reflected that the category of registration with the HPCSA impacted their clinical conceptualisations of intellectual disabilities. Their subject position was entrenched in their professional identities e.g. medical practitioners, psychologists, etc. Two sub-themes emerged. Table 6 reflected the sub-themes with illustrative quotes.

Table 6. Theme 5- Professional identities.

Sub-Theme	Illustrative quotes
1 Category of registration	'I do what I have been trained to do. As a nurse I have learnt how to assess and understand this patient and how he should be handled.' (g2, p8)
	'I got so annoyed when the registrar would walk into a meeting I was having with my patient. I adhere to strict boundaries as a psychologist and don't want lines crossed.' (g2, p18)
	'So many patients with cognitive difficulties need grants and a different kind of management that falls outside of my scope.' (g1, p1)
2 Discourses on team and service users	'Patients are patients, they all need to be helped and taken care of. The team though is very different. Each one brings a very specific set of skills and together we make a team.' (g1, p5)
	'So there is really a clear sense of who does what and your place in the pecking order. It is quite something to see who speaks and makes a contribution depending in who is in the room. Certain people are never challenged while others are ignored and overridden.' (g1, p2)
	'…but sometimes I think lines get crossed. There is a subtle push to take on like case management and therapy from disciplines without the training. It concerns me, like it can water things down and we can lose the beauty of the MDT (multi-disciplinary team).'

Sub-theme 1: Category of registration. The registration category provided a professional identity that informed the scope of practice and code of conduct. This identity positioned them in multi-disciplinary teams and provided a framework for working across and within their professional registrations. The participants reflected that their professional registration influenced the nature of their training, collegial relationships, hierarchical/professional standing, clinical foci, and the nature and type of service learning they were exposed to.

Sub-theme 2: Discourses on team and service users. Participants all reflected that within their professional identities they developed a clearly delineated sense of their relative contribution in the context of multidisciplinary teams. Participants underscored the multi-disciplinary nature of the team and readily engaged with this intersection of diversity within the team whilst service consumers were seen as a homogenous group. Participants engaged rigorously with the professional differences in the team and demonstrated their ability to think abstractly of what they accepted their user group not to be capable of. Participants expressed anxiety about the integrity of their respective scopes of practice, as the discussion broached other ways of working e.g., trans-disciplinarity.

Discussion

The first theme suggested that Health professionals identified intellectual disability as a clinical issue. Health professionals identified that people with intellectual disabilities would not possess the baseline intellectual capacity to be able to identify feelings and perceptions about otherness in oneself and others. This extends to the ability to express those feelings as communication is an aspect of adaptive functioning. This view is consistent with the diagnostic criteria that identifies compromised capacity in intellectual and adaptive functioning (APA, 2013). This served as a justification for professionals to adopt the stance that intellectual disability is essentially a clinical issue. The participants acknowledged that there are levels of intellectual disability and that there was functional interaction between levels of intellectual disability. The results suggest that participants related the varying levels of functioning to case management and treatment planning rather than to the extent to which diversity could be conceptualized as something that people with disability could engage with This view reflected the experience of the participants in tertiary care with higher levels of disability (Adnams, 2010). People with borderline intellectual disability often are not appropriately diagnosed and do demonstrate the capacity to identify that they are different from others even if they cannot always articulate it (Phillips et al., 2016). Thus, this kind of view negatively impacts on a more holistic view of people with intellectual disabilities as a heterogenous group.

The participants in this study expressed concerns about the usefulness of framing diversity for people with intellectual disabilities as they engaged with it as a clinical diagnoses characterized by the lack of capacity in the cognitive realm. This findings was consistent with the literature where were seen as distinct from diversity (Jirwe et al., 2009). The assumption that intellectual disabilities and the subjective awareness of difference are mutually exclusive is consistent with the one-dimensional construction of difference (Trentham et al., 2007). What became evident was that professionals deferred to clinical conceptualisations as a default position from which they argued that persons with intellectual disabilities cannot or would struggle to engage with diversity given the reflexivity and abstract thinking that was assumed to be required (Matthews-Juarez and Juarez, 2011). The impairment of cognitive and adaptive functioning may limit that capacity, but does not necessarily preclude or detract from the subjective experiences of being different on the basis of intellectual disabilities and its intersection with other traditional dimensions of diversity. This also impacts on diagnostic overshadowing where legitimate medical and socio-cultural issues may be

erroneously attributed to the intellectual disability that dismisses the lived reality of the person with intellectual disability. This default position was adopted at the expense of alternate constructions. For example, intellectual disability as a dimension of otherness that was conceptualized socio-politically and not only clinically. In so doing, it would constitute a level of diversity (Trentham et al., 2007).

The second theme identified that the aetiology of intellectual disability influences the subject position of practitioners and the ethic of care that was adopted in service delivery. The clinical and custodial care reported in this study was consistent with the literature reporting on the impact of clinical stances on service delivery for the intellectually disabled (Butler et al., 2011; Matthews-Juarez and Juarez, 2011). These two preferred responses in the ethic of care of people with intellectual disabilities mean that advocacy is limited to the sequelae of clinical or functional impairment. Advocacy is an important indirect service that deals with the extent to which services and conditions for living and learning are geared to be inclusive of people with intellectual disabilities (Roberts, 2006).

The third theme identified that there was great variation in the level of training or the extent to which intellectual disability was dealt with between the professions represented. The findings suggest that the stereotypical approach to diversity training did not promote engagement with non-clinical aspects. This finding was consistent with literature over the last two decades reporting that health profession students became desensitized from hearing the same issues in diversity training and developed stereotypical representations of minority and vulnerable groups (Kai et al., 1999; Matthews and Van Wyk, 2018).

Across disciplines training focused on clinical management at the expense of engaging in indirect services consistent with the findings of Butler et al. (2011). The lack of training in indirect services is concerning in terms of competency-based training. In addition, indirect services have a built-in focus on reasonable accommodation and the construction of difference on the basis of the impairment (Alhejji et al., 2016). Aronson et al. (2005) underscored that diversity training should pay attention to the core aspects that underpin indirect services such as advocacy. Matthews and Van Wyk (2018) asserted that education on diversity and ethnicity must empower health professionals unlike the report of disengagement and desensitization.

The fourth theme identified that service learning and immersion into placements augmented the theoretical component of training. This learning was reportedly more comprehensive than the theoretical component of the respective courses completed (Jacob et al., 2020). The findings resonated with seminal work reporting that experiential learning such as immersion programmes were effective and powerful interventions (Crampton et al., 2003). Participants reflected that immersion into the challenges of intellectual disabilities at a personal or structural/institutional level became the primary motivation for being involved in this work.

Participants also reflected that there were some challenges associated with experiential learning. The clinical settings where service learning took place were often under-resourced and presented urgent and immediate service needs. This resulted in reduced opportunity to reflect on their experiences through supervision and reflexivity (Stewart and Wubbena, 2015). This finding was identified as a concern for student practitioners whose reflexive learning about their work, the placement and their developmental needs were secondary to legitimate and urgent operational service needs (Wald et al., 2012). Similarly, Adegbola (2013) and Bhopal (2009) cautioned that professional training must not become reliant on or over emphasise experiential learning without considering the known challenges and impact on learning.

The fifth theme suggested that registration categories and professional identities represented another level of diversification. Their registration categories introduced an intersecting dimension of

diversification that is accepted as a default of multi-disciplinary teams and not engaged with critically. Through these identities they had differential access to theory and praxis that in turn informed the extent to which they were prepared to engage with issues of diversity per se and intellectual disabilities in particular. Therefore, the development of multi-modal curriculum and co-curricular activities must be leveraged to promote the development of multicultural and diversity competence (Arruzza and Chau, 2021). The discourse on the multidisciplinary team underscored diversity and introduced more intersecting dimensions whereas the discourse on the target group of patients with intellectual disabilities remained undifferentiated (Murray-Garca et al., 2005, 2014).

Conclusion

The findings revealed that clinical training was compromised due to time constraints, service-learning demands, and changes in the academic landscape. Given these demands, clinical training does not succeed in producing health professionals who feel competent and confident in dealing with issues of diversity. The study underscores the importance of more careful reflection on the role of higher education in the development of curricula that will facilitate the development of competence in diversity amongst health professionals. Training in diversity represents a small aspect of the overall curriculum and is approached from traditional conceptualizations using social and political constructions of identity. As such, intellectual disabilities are not sufficiently interrogated as an aspect of identity. There are numerous intersections within diversity due to race, gender, etc., in addition to clinical presentations of intellectual disabilities that pose major challenges to conceptualising and managing diversity. The professional identities of health professionals constitute another level of diversification that is not adequately reflected upon in multidisciplinary teams. The lack of reflexivity in this regard results in the subject position of practitioners being overlooked. In multidisciplinary teams, the professional identities and the construction of treatment teams must be interrogated as they provide another intersectional challenge in diversification. In short, health professionals struggle to conceptualize intellectual disabilities as a diversity concern and expressed concerns about the usefulness of the construction.

Recommendations

Diversity training for health care professionals must be more intentional and comprehensive in dealing with diagnoses such as intellectual disability. Training needs to be theoretically grounded to equip professionals with a more comprehensive and inclusive conceptualization of diversity, and the skills to effect the related imperatives to provide reasonable accommodation. Constructions of intellectual disabilities and professional identities should be explored as additional dimensions of diversity. Future research could explore the perceptions of health educators, as well as the perceptions of professionals engaged in advocacy with this population which might provide a different view or finding.

Reflections and limitations of the study

This study only accessed the perceptions of health professionals and did not specifically engage clinical educators or trainers, nor with health professionals employed in social service agencies that deal specifically with advocacy for people with intellectual disabilities. The study did not engage with the criteria or guidelines stipulated by the HPCSA with regard to the relative focus placed on diversity training in general and intellectual disabilities per se.

Declaration of conflicting interests

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Ethical approval

Ethics clearance was obtained from the Senate Research Committee of the University of the Western Cape. Permission to access health professionals was obtained from their respective employers. Information sessions were facilitated with employers and eligible participants to explain the study and what participation would entail. It was underscored that participation required reflection on professional training and not the efficacy of the place of employment. Thus, places of employment were considered for the purposes of recruitment rather than as a unit of analysis. Formal invitations and information sheets were issued to potential participants via their respective employers. All participation was voluntary and written consent was obtained. Participants signed a binding confidentiality agreement to keep the content of the groups and identities of participants confidential. Participants agreed to the proposed dissemination plan. Third party harm was avoided by anonymising places of employment and training institutions. Employers and participants were given the option of proofreading disseminations to avoid third party harm or accidental disclosure of identities. Transcriptions were anonymised.

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