**Nursing Standard**

**Developing Culturally Competent Mental Health Skills**

--Manuscript Draft--

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| **Manuscript Number:** | NS12067 |
| **Article Type:** | A&S general article |
| **Full Title:** | Developing Culturally Competent Mental Health Skills |
| **Short Title:** | Cultural Competent Health |
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| **Abstract:** | Adult nurses working in diverse environments will come into contact with people who happen to have a mental illness diagnosis. A lack of opportunity to develop specific skills, or a lack of confidence in approaching people who may behave in unfamiliar or challenging ways can result in adverse care experiences for patients. Person critical reflection, confidence building and specific knowledge can assist adult nurses in meeting this need. |
| **Keywords:** | Mental illness, adult nursing, cultural competence |
| **Additional Information:** |  |
| **Question** | **Response** |
| Have all named authors contributed to the article and reviewed and approved its content before submission? | Yes |
| Please confirm that you have read and agree to our Publisher's Agreement that is available <a [href="http://rcnpublishing.com/userimages](http://rcnpublishing.com/userimages)/ContentEditor/1375795144242/NS%20P ublisher's%20Agreement.pdf">here</> | Yes |
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| What is the word count of your article including the abstract, body text, boxes, tables and figures, and references? | 3557 |
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[7.10.22 (1).docx](https://www.editorialmanager.com/rcnp-ns/download.aspx?id=26195&guid=ab683e2e-bb4d-4386-bbfd-7c39b6b1b4ac&scheme=1)

Developing Culturally Competent Mental Health Skills

Abstract

Adult nurses working in diverse environments will come into contact with people who happen to have a mental illness diagnosis. A lack of opportunity to develop specific skills, or a lack of confidence in approaching people who may behave in unfamiliar or challenging ways can result in adverse care experiences for patients. Person critical reflection, confidence building and specific knowledge can assist adult nurses in meeting this need. The concept of cultural competence may provide useful principles on which to make this change.

Keywords

Mental illness, adult nursing, cultural competence

Key points

Adult nurses may need reassurance that they have skills to help people who happen to have mental health problems

There are many interventions and approaches that adult nurses can use in practice to ensure good quality experiences for people with mental health problems

Adult nurses may need to open themselves up to critical reflection and acknowledge what they can change in their approaches to people with mental health problems to ensure good experiences.

Introduction

Have you ever looked at the clinical notes of a new admission and seen for example, ‘schizophrenia,’ ‘personality disorder’ or ‘bipolar disorder’ written there and felt your heart sink? Or felt fear or anxiety and thought, ‘I don’t know about this, I don’t know what to do’? If so, you are not on your own as in our experience this is not uncommon. This paper aims to address such feelings and engender confidence that your skills can be used effectively for people who need nursing care but who happen to have a mental illness diagnosis. This requires you to approach what you read in a reflective manner, to accept that although there is evidence of good care, there is also evidence of poor care outcomes for people with mental illness (Royal College of Psychiatrists, 2014) and poor experience in health services (Derblom et al 2021; Sharda et al 2021). By making a commitment to developing your own cultural competence, not just in relation to ethnicity and race, but to broader issues of diversity and potential disadvantage such as mental illness, this can be overcome.

Establishing your fundamental skills

The concept of cultural competence share two basic assumptions; it is a necessary condition for working

effectively with differences, and, it can be taught, learned, trained, and achieved (Campinha-Bacote,

2018). It also concerns a focus on improving interactions between individuals (Buchanan et al 2020).

Although there may be people who dislike the term cultural competence, and recent literature argues that

intersectional analysis allows for a more complex focus on the simultaneous analysis of oppression and

privilege (Buchanan et al 2020), this paper with maintain a focus on cultural competence due to its more

practical focus which are congruent with the papers aims. However, the concept of ‘cultural humility’ (Lee and

Haskins, 2022) associated with a the more complex intersectionality, purports that we may never be fully

Culturally competent but should seek to have genuine conversations with a view to trying to understand

someone’s identity. Whilst the idea of cultural competence is rapidly becoming more embedded in practice

with regards to issues such as race, ethnicity and sexual orientation for example, it is also important to

consider how this applies to other aspects of people’s identity such as being diagnosed with a mental illness,

which can be quite disabling.

In the context of disability, cultural competence will include thinking about how language evolves and changes

to construct inclusive environments. It is vital to keep an open and reflective approach as we will all, at some

point, say the wrong thing (Dunn and Andrews, 2015; Botha, Hanlon, and Williams, 2021). Showing we are

making an effort to be respectful may be most important.

It is also necessary therefore to consider how we refer to things such as emotional distress. When expressions

of distress are labelled as ‘purely’ a mental illness we can forget the personal nature of that distress and what

it is communicating. Focusing on the diagnosis to the exclusion of this can be limiting when a genuine human

connection is required (Isobel *et al.*, 2021). Negative reporting in the media is known to promote negative

attitudes in relation to people with mental health problems (Rose et al 2007), and nurses are exposed to this in

the same say as others. As professionals, critical reflection can often result in new realisation and awareness,

but this takes time. Cultural competence is a long-term commitment.

Overcoming Your Challenges

Health professionals may not prioritise mental health awareness in the time available for continuing professional development (Nutt & Keville 2016). Understanding that contemporary efforts in mental health care aim to develop more democratic approaches may be useful, adopting an attitude that respects service user as experts in their own lives and needs, and any attempt to interpret their experience from our own perspective potentially problematic (McLaughlin, 2009). Patient expertise is also acknowledged in general hospital/community settings of course, but the stigma and history of disbelief regarding people with mental illness brings a multifaceted range of challenges (Horgan *et al.*, 2020).

There is a long history of disbelief, disempowerment, and stigmatisation that all too easily finds its way into practice through personal attitudes and how these are conveyed by professional staff, in language and action (Clarke *et al.*, 2014: Mulhearne, P. *et al.*, 2021). So, perhaps it is beliefs and attitudes that require the most attention, to evaluate our own position, understand where our perspectives come from and attempt to challenge ourselves. This can be painful. We must be willing to listen, hear the feedback service users provide (whether face to face, in evaluations or reported in research) and to go through the uncomfortable process of accepting how far we have contributed to any poor experiences.

Diagnostic labels are potentially influential in this. Sharda et al (2021) report one participant describing being treated well until the diagnosis of personality disorder was disclosed, when things changed. Consider what ‘personality disorder’ means to you. Perhaps if you reflect on that you might write, ‘unreliable,’ ‘manipulative’ or ‘dangerous.’ These are certainly powerful messages fed to us through media and news over time (Pass, 2017). But what if we understood that people who meet such psychiatric diagnostic thresholds in fact commonly report histories of abuse, violence and sexual exploitation as children, and that this has meant their emotional development was halted, that the structure of their developing brain was impacted, and that they now find it very difficult to develop constructive relationships, to have empathy or self-awareness to communicate effectively, to cope with everyday life (Asmundson and Afifi, 2020; Isobel *et al.*, 2021).

If a busy nurse seems a little brusque, someone with a trauma history is easily taken back to destructive patterns in relationships that dismissed, undermined, and neglected their needs. Sharda et al (2021) suggest that experiences of repeated patterns of communication mirror those that occurred in origins of trauma, and Derblom et al (2021) found feelings of neglect, dismissal, judgement, mistrust, all recognisable within such patterns. Nurses may not be aware that simple act of turning away may be experienced as part of this pattern, as some people will be hypersensitive to such behaviours and may have specific interpretations that trigger the trauma of past neglect and abuse. This then may result in what may be seen as difficult behaviour such as screaming, or self-injury, as the only way of communicating distress (Sharda et al 2021). If that distress is responded to, rather than perceived as difficult behaviour (the implication here being because it is seen as wilful and deliberate) the outcome is likely to be different. A diagnostic label of mental illness may enable us

to dismiss their behaviour as ‘their illness’ or to dismiss its meaning, whereas looking at this through an experiential lens can change both the experience and outcome.

Diagnostic labels tell us little about individual experience, but the weight they carry can be enormous. We think we know what they mean. Try the same exercise with ‘schizophrenia.’ Where does your notion come from? Psychosis is one cluster of symptoms in the diagnosis of schizophrenia, and this means experiencing frightening hallucinations, visual, auditory, tactile, olfactory, or oral, but they often have personal meaning or origin. Delusions, a medical term for experiences that have no physical evidence and are not shared, are for an individual their reality. Asking questions of someone’s experience is validating, being curious is respectful.

Asking, ‘can you tell me more’ or explaining that you do not see things the same way is OK. Being kind and nice and not turning away when someone is screaming or hurting themselves shows that someone cares and is willing to try and help.

What We Can Do

Nurses and other health professionals, irrespective of their specialism, will have personal

experience of episodes of poor mental health and may have encountered and

provided support in many situations where people face life-changing events related to

serious diagnoses, or losses and bereavements. This experience should underpin personal confidence. Be

confident in your own skills but remain reflective. You have (or can learn) the skills and knowledge, but may

feel limited in understanding how to respond (Barratt, 2013). You need to be sensitive to the concepts of

social justice, equality of access, social inclusion and be willing to tackle exclusion (Trenoweth, 2022).

A patient who is in crisis will be in ‘fight, flight or freeze’ mode which is likely to result in the inability to think clearly, and to act emotionally and impulsively. Think about the environment, on a physical health ward or in a busy A&E department, for example, and how this can impact on the person’s existing emotional state. The first step when approaching such patients is to help them feel safe, both emotionally and physically. This can be achieved with small practical steps, by making some minor changes to their environment, and through your interaction and your communication with them.

Thinking about the five senses can act as a guide to help you to find ways to alleviate distress. Overstimulation is likely to escalate their negative emotions and behavioural responses (Isbell *et al.*, 2020). Ask yourself, what is the person seeing and hearing? As healthcare professionals, we can perhaps become de-sensitised to the pain and suffering that surrounds us at work (Clarke *et al.*, 2014) and may not be affected by it in the same way as a new patient entering that ward or department can. It can therefore help to identify a quiet room, or a quiet area, for that person to sit in. Can the brightness of the lighting in this area be reduced? Some quiet

rooms offer ‘sensory lighting’ that glow different colours or specific lighting equipment used for this purpose.

Acknowledge your own feelings as well as theirs (Holland *et al.*, 2020). Expression of emotion is communication, and it is important to identify what your own feelings are telling you. For example, do you have the urge to withdraw, run away, avoid? These feelings are associated with the same anxiety or fear of the situation that patients might be feeling. For nurses these feelings might be due to worrying about saying ‘the wrong thing’ (Clarke *et al.*, 2014). Acknowledge these feelings and approach the situation anyway, resisting the temptation to avoid.

Your communication style, both verbal and non-verbal, is essential in helping the person to feel safe. Ask them initially what would help them to feel safe, and if you are able to, do it. There is a vast array of literature that has been published to help healthcare professionals improve their confidence and ability to communicate effectively with patients who are in distress. We have included some of the important elements of communication that will help you to establish, build and maintain a therapeutic relationship in adult nursing environments referred to in the documents referenced (see table 1).

**Table 1** Suggestions to help people in distress

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| **Documents that inform this information** | -Star Wards &Cambridge university hospitals NHS trust (2014) Brief encounters. <https://www.starwards.org.uk/brief-encounters-pub/>-Star Wards (2010). Talk Well. Encouraging the art of conversation on mental health |
|  | wards. [https://www.starwards.org.uk/wp-](https://www.starwards.org.uk/wp-content/uploads/2019/02/TalkWell_2nd_Edition_4.1mb.pdf) |
|  | [content/uploads/2019/02/TalkWell\_2nd\_Edition\_4.1mb.pdf](https://www.starwards.org.uk/wp-content/uploads/2019/02/TalkWell_2nd_Edition_4.1mb.pdf) |
|  | -Talking with acutely psychotic people. Communication skills for nurses and others |
|  | spending time with people who are very mentally ill.[https://www.researchgate.net/publication/257230982\_Talking\_with\_Acutely\_Psychoti](https://www.researchgate.net/publication/257230982_Talking_with_Acutely_Psychotic_People_Communication_Skills_for_Nurses_and_Others_Spending_Time_with_People_Who_Are_Very_Mentally_Ill) |
|  | [c\_People\_Communication\_Skills\_for\_Nurses\_and\_Others\_Spending\_Time\_with\_Peopl](https://www.researchgate.net/publication/257230982_Talking_with_Acutely_Psychotic_People_Communication_Skills_for_Nurses_and_Others_Spending_Time_with_People_Who_Are_Very_Mentally_Ill) |
|  | [e\_Who\_Are\_Very\_Mentally\_Ill](https://www.researchgate.net/publication/257230982_Talking_with_Acutely_Psychotic_People_Communication_Skills_for_Nurses_and_Others_Spending_Time_with_People_Who_Are_Very_Mentally_Ill) |
| **Preparation** | Read the person’s case notes, have they presented before? Is there anything in thenotes that might indicate what could help them? |
| **Introduce self** | Explain your role, and make yourself available and approachable |
| **Focus on the****person** | Sit with them, establish eye contact, show as well as tell them you are here for them.Try not to get distracted by other tasks. |
| **Accept and listen** | Accept the person’s reality, ensure you listen to them and show understanding – forexample, repeat back to them what you have heard. |

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| **Validate and****offer empathy and concern** | Articulate things like, ‘I understand that must feel very upsetting’; ‘I’m not surprised that you find it difficult to talk about this’ |
| **Stay calm** | This can feel very difficult when you have somebody presenting to you in distress, butif you appear calm to the person, this will help them to also feel calmer. |
| **Body language** | If possible, sit down next to the patient so you are on the same level. Try to sit still and have an open body posture; this shows you are interested in listening to them. Give the person an appropriate amount of eye contact – this can be difficult to gauge at times but try to match theirs. However, be careful not to misinterpret any lack of eyecontact when culturally this may be a sign of respect. |
| **Speech** | Speak clearly and calmly, think about your tone and volume of your voice. It can be easy to speak fast and loudly when you are in a busy ward environment. If you findyourself doing this, try to correct yourself. |
| **Time** | Allow the person time to cry, or to be upset in your presence. This can be hard when you are working in a busy environment with endless tasks to complete, however this will be highly beneficial for that person and may prevent more complex issues arisingthat need attention. |

Some of the suggestions in table 1 will not necessarily be new to you. However, consider them in the context

of the discussion provided in this paper and how these can be applied. You may also consider you’re the

professional rationale for all this. Table 2 summarises a selection of national and international context for

healthcare practice that underpins a nurses goals for effective and inclusive care. Although these documents

may appear to be aimed primarily at policy makers, they include their own useful resources for

helping you put some of this into practice in a meaningful way.

Table 2 A selection of policy and practice guidance that underpins nursing care

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| **Comprehensive World Mental Health Action Plan 2013-2030 (World Health Organisation, WHO, 2022)**[**https://www.who.int/publications/i/item/9789240031029**](https://www.who.int/publications/i/item/9789240031029) |
| Presents objectives and actions to promote mental health and wellbeing for all, to prevent mental healthconditions for those at-risk, and to achieve universal mental health coverage for all across the lifespan |
| **World Mental Health Report: Transforming Mental Health for all (WHO, 2022)**[**https://www.who.int/publications/i/item/9789240049338**](https://www.who.int/publications/i/item/9789240049338) |
| Draws on the latest evidence available, showcases examples of good practice from around the world, andincludes people’s lived experience in order to promote better mental health care for all |
| **The Code, Nursing and Midwifery Council (NMC, 2018)**[**https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf**](https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf) |
| Prioritise People, Practise Effectively, Preserve Safety, Promote Professionalism and TrustWe are committed, as nurses, to uphold the standards of The Code and therefore we must prioritise our patients’ care and safety and ensure their needs and interests are treated holistically |
| **No Health without Mental Health (Department of Health, DH, 2011)** [**https://www.gov.uk/government/publications/no-health-without-mental-health-a-cross-government-**](https://www.gov.uk/government/publications/no-health-without-mental-health-a-cross-government-outcomes-strategy)[**outcomes-strategy**](https://www.gov.uk/government/publications/no-health-without-mental-health-a-cross-government-outcomes-strategy) |
| Mental health is “everyone’s business”, we all must play our part in improving patients’ experience of careand support and to reduce the stigma and discrimination that people with mental health problems often face |
| **The Five Year Forward View for Mental Health (Mental Health Taskforce Strategy, 2016)**[**https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf**](https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf) |
| A strategy that is built on the fundamental principle that mental health should be seen with equalimportance to physical health, regardless of the NHS service the patient is receiving |
| **The National Confidential Enquiry into Patient Outcome and Death. Treat As One. (NCEPOD, 2017)**[**https://www.ncepod.org.uk/2022phmh.html**](https://www.ncepod.org.uk/2022phmh.html) |
| We need to bridge the gap between mental and physical healthcare in general hospitals, with ‘many more clinicians contributing to improve the patient journey at each step of the way’The workforce needs to understand this mental-physical healthcare gap, and receive education and trainingin order to develop the confidence and competence to bridge these gaps at every level of the service |

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| Mental illness is often integral to a patients’ physical health problems, and neither should be treated inisolation |
| **Side by side: A UK-wide consensus statement on working together to help patients with mental health needs in acute hospitals. Royal college of psychiatrists (2020)** [**https://www.rcpsych.ac.uk/docs/default-**](https://www.rcpsych.ac.uk/docs/default-source/members/faculties/liaison-psychiatry/liaison-sidebyside.pdf)[**source/members/faculties/liaison-psychiatry/liaison-sidebyside.pdf**](https://www.rcpsych.ac.uk/docs/default-source/members/faculties/liaison-psychiatry/liaison-sidebyside.pdf) |
| Recommend three principles to enhance the collaboration and working together of mental health professionals and those working in acute medicine in order to meet the needs of patients: dignity and easeof access, working side by side and clarity of communication |
| **NICE Guidelines: ‘Self Harm: assessment, management and preventing recurrence’, (National Institute for****Health and Care Excellence, NICE, 2022)** [**https://www.nice.org.uk/guidance/ng225**](https://www.nice.org.uk/guidance/ng225) |
| Supporting patients’ mental health needs who present with self-harm will not only be the responsibility of mental health professionals. NICE is making it “everyone’s business” – all health and social careprofessionals will have a part to play |

**Conclusion**

There is a regulatory obligation to commit to lifelong learning for nurses, and to practicing according to ethical codes. A cultural competence approach to putting such codes into practice may help make such goals meaningful and achievable over time when faced with highly stressful work environments. The skills required to ensure that people who happen to have a mental illness diagnosis experience good nursing care are available to adult health nurses if a commitment is made to personal reflection and change. Critically reflecting on the fundamental knowledge and attitudes explored in this paper will provide meaningful way of engaging in this lifelong development.

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