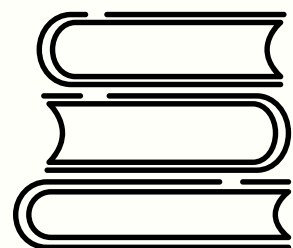
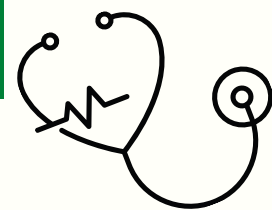




CONNECTED VOICE CULTURAL  
COMPETENCY TRAINING

# FURTHER RESOURCES FOR PRACTITIONERS

IN COLLABORATION WITH  
MENTAO HEALTH



# CONTENTS

- 1) Resource Purpose
- 2) Cultural Competency
- 3) Practitioner Stumbling Blocks and Best Practice Tips
- 5) Key Takeaways
- 6) Additional Resources and References

**This resource is designed to help attendees of the Cultural Competency Training by:**

- Providing greater **context** for the knowledge shared in the training module, to enhance long-term understanding
- Increasing practitioners' confidence in applying the information learned by providing examples of **real-life applications** and **challenges** to cultural competency and how to navigate this topic with sensitivity, compassion and curiosity
- Encouraging new ideas for improvement in their own practice with a wide range of anecdotes from the UK
- Providing an information base from which you can engage in your own conversations and inquiries

# CULTURAL COMPETENCY

The foundational principles of cultural competency are:

1. Open Attitude
2. Self-awareness
3. Awareness of others
4. Cultural Knowledge
5. Cultural skills

By approaching issues with an **open attitude** and increasing our **awareness** of ourselves and others, we gain **cultural knowledge**. With practice, this develops into **cultural skills**, which then helps us to tailor the services to match the communities we serve.



Cultural humility lies at the heart of cultural competency

- The language in this field is constantly evolving.
- Many communities and practitioners find it more respectful to talk about cultural humility.
- At its core, cultural humility means we are able to recognise that our perspective is just that: our own perspective.
- This phrasing makes people feel like their cultural values and beliefs are honoured and respected.
- For many, this perspective feels less Western-centric and more inclusive.

# GENERAL TIPS

**There are 8 principles for greater cultural sensitivity and awareness:**

1. First do no harm by stereotyping.
2. Recognise that culture extends beyond appearance.
3. Find out each patient's cultural background.
4. Conduct culturally sensitive evaluations.
5. Find out the patient's expectations and preferences.
6. Understand how your own cultural identity affects your practice.
7. Keep questioning our own assumptions.
8. Remember that culture is dynamic and ever-changing, so continued learning is key.

- **Identify the ethnic mix of your practice population.**
  - What are the main spoken languages?
  - What is the level of English fluency?
  - What are the main religions?
  - Are any related significant events, risks or complaints, e.g. different BMI risks?
- **Provide multilingual information materials, such as practice leaflets or information sheets.**
- **Identify particular skills required for multicultural interactions and consider further training and role development for all staff members.**



# TIP - LANGUAGE AND INTERPRETING

In the North-East, Asian Chinese, Asian Bangladeshi and Arab communities have the lowest English literacy rates:

Location: England and Wales  
Time period: 2011  
Source: England and Wales 2011 Census

Percentage of people who couldn't speak English, by ethnicity and region

Ethnicity	North East	North West	Yorkshire and The Humber	East Midlands	West Midlands	East of England	London	South East	South West	Wales
Arab	3.0	2.2	2.8	2.4	2.8	1.6	1.4	1.0	1.2	2.8
Asian Chinese	2.7	3.2	2.4	1.7	2.8	1.9	2.2	1.8	1.7	2.9
Asian Bangladeshi	2.6	3.5	3.3	2.6	3.5	2.5	3.1	1.9	1.5	2.7
Other White	1.7	1.9	2.7	2.5	2.3	1.8	1.3	1.1	1.3	2.5
Asian Pakistani	1.3	2.0	2.7	2.0	2.8	1.9	1.1	1.6	0.7	1.2
Other Black	1.0	0.6	0.8	0.5	0.4	0.2	0.6	0.4	0.7	1.5
Any other	1.0	1.3	2.2	2.0	2.1	0.8	1.7	1.0	1.4	2.3
White Gypsy/Traveller	0.6	1.2	1.7	1.5	0.8	0.5	2.6	0.3	0.3	0.4
Asian other	0.6	1.3	1.5	1.4	2.0	0.7	1.4	1.3	0.8	1.2
Asian Indian	0.5	1.2	1.1	2.5	1.7	0.6	1.3	0.7	0.5	0.6
Black African	0.4	0.7	0.7	0.5	0.6	0.2	0.5	0.2	0.7	0.9
Other Mixed	0.3	0.4	0.7	0.5	0.8	0.4	0.6	0.2	0.2	0.2
Black Caribbean	0.3	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Mixed White/Black African	0.2	0.2	0.6	0.2	0.4	0.3	0.6	0.2	0.2	0.2
Mixed White/Asian	0.2	0.2	0.4	0.2	0.2	0.2	0.5	0.1	0.2	0.3
Mixed White/Black Caribbean	0.1	0.0	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.1
White British	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
White Irish	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0

There often isn't a clear cut answer on how to solve cultural competency issues, so just use your best judgement.

- For example, how do you navigate the language barrier issue and prioritise confidentiality in a situation when the community is small and the interpreter could potentially know our patient?
- In this case, consulting with the patient regarding their preferences would be advisable.

It's worth bearing in mind that interpreters and translators usually have different levels of experience and skill.

- An interpreter is professionally trained, whereas a translator can be good at literal translations but they may also mistranslate or miss important nuances and meanings.

# STUMBLING BLOCKS AND TIPS

- Practice questioning your own unconscious biases and try not to let stereotyping influence your assessments.
- Instead, use your existing cultural knowledge as a starting point to ask more questions about an individual.
- On a broader level, certain ethnicities and groups may demonstrate a particularly strong preference for particular behaviours when it comes to culturally sensitive needs.
- Often there is as much diversity within ethnic groups as between them. Just think of yourself and your own ethnic group and the huge diversity amongst everyone across age, class, gender and more.

“ From my experience with Aboriginal patients, what I saw from them was totally different from the workshops. You attend these workshops and then you sit with a patient and you expect this stereotype.

It kind of limits you to what to expect and you feel that you have got it all when you don't really have a clue about what's happening with them and sometimes we approach this consultation with that attitude. I had attended workshops - I should know you, I know you back-to-front and front-to-back. But the reality is different. ”

— GP, Australia

# PRACTITIONER TIPS - WHERE TO BEGIN

- **Building good communication is the key to an empowering patient-practitioner relationship**
  - Pay close attention to body language, lack of response, or expressions of anxiety that may signal that the patient or family is in conflict but perhaps hesitant to tell you.
- **Try to understand the extent to which the patient identifies with British culture**
  - Patients who are highly embedded in the native culture may be totally committed to their original culture.
  - People who are less embedded and more acculturated may value open communication and ideas from both cultures.
  - Bicultural individuals can move easily between both cultures.
- **Where appropriate, inquire about the process of immigration for the patient.**
  - Such individuals often have had frequent moves or repeated changes before and after the migration, leading to physical and psychological rootlessness that can lead to physical manifestations of stress that they may perhaps not be aware of.

Example of questions to bear in mind:

- What country did the patient immigrate from and how different is the native culture from British culture?

# PRACTITIONER TIPS

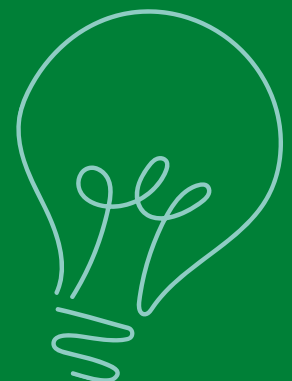
## - CULTURE

- Ask questions to understand the meaning of the illness in terms of the patient's unique culture.

- What practical skills do we need to safely explore our cultural differences?

Example questions:

- What do you think has caused your problem?
  - What kind of treatment do you think you should receive?
  - What are the most important results you hope to get from this treatment?
  - What do you fear most about your illness?
  - Would you like a female interpreter?
- Consider the patient's family structure, if there are intergenerational differences and who the decision maker is.
    - In situations where there may be a intergenerational difference, you may observe tension between acculturated children who want older members of the family to take advantage of Western medical practices and older members of the family who wish to follow traditional remedies.
    - The challenge is not to become involved in the intergenerational struggles, but to respect the two positions and allow opportunities for teaching that recognise the importance of both generations.

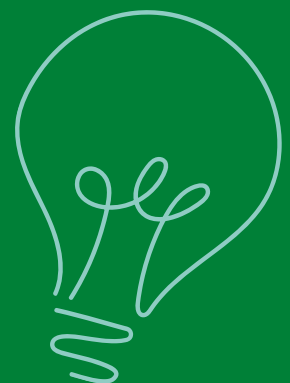




# PRACTITIONER TIP

## - BUILDING TRUST

- Ask the patient and family open-ended questions to gain more information about their assumptions and expectations.
- Remain non-judgmental when given information that reflects values that differ from yours.
- Follow the advice given by patients about appropriate ways to facilitate communication within families and between families and other health care providers.
- Traditional dietary habits should be acknowledged, respected, and incorporated into patient teaching plans.
- Religions and dietary customs may influence scheduling patients for checkups, e.g. Fridays being less popular amongst practising Muslims.
- There are also lower BMI thresholds for patients of South Asian/Chinese/Middle Eastern Ethnicity - so they can be referred with a BMI of >27.5 rather than >30."



# PRACTITIONER TIPS

## - VALUES

- **Consider moving beyond a person-centred approach to a family-centred approach, where appropriate**
- **Seek out culturally specific community services in your area.**
- **Where these are not available, discuss patient and family needs with local service providers.**
- **Learn about the cultural traditions of the patients you care for.**
  - Get to know the values and beliefs around family structures. Who is the decision maker? Who is responsible for the care of the family member?
  - Understand the beliefs around health and illness and attitudes to hospitalisation.
  - What are their preferences around privacy?
  - How much agency is expected from the patient? Might they prefer to be in a more passive role?
- **Don't be afraid to reach out to your social wider circles to broaden your frame of reference. Again, feel free to use your cultural knowledge as the starting point for conversation.**

“ I consulted with my Chinese friend on why my patient wanted to give birth on a specific date and time. Was there a cultural significance?

My friend was able to refer me to some spiritually significant dates and cultural beliefs that may be relevant to this situation.”

— GP, Manchester, UK

“One of the family had called Viet Nam and had the dying patient's fortune read. The family was told this was not only a terrible bad luck day for the patient to die (bad for rebirth) but also would be bad luck for the family. The patient had to be put back on life support to be kept alive.

The [Vietnamese] family takes care of the dead. I think the best thing a nurse can do is just to be physically present. Their eyes must be closed after they die because we believe that if their eyes are still open after their death then they still have things they can't let go and their spirit will linger until the tasks or wishes are done.”

— Vietnamese American GP



“When participating in cultural negotiation, nurses can use other health care providers who are from the patient's own cultural group.

However, it is important to remember that, if there is a large gap between the beliefs of providers and patients, and if providers are westernised, they may distance themselves or look down on those who hold traditional beliefs.

When this happens, the care providers cease to be therapeutic, even though they share a common cultural heritage. It is important to remember that language alone does not ensure cultural understanding. Patients and care providers from the same country may come from different class and social structures and may not always communicate effectively.”

— UK South Asian GP



“ I prefer to talk about honouring cultures and practising cultural humility. It's also really important to continue engaging with community services so we can constantly learn how to better listen and understand.”

— US AAPI (Asian American Pacific Islander) practitioner



“ Some cultures, such as Native American cultures, may value nonverbal and more passive approaches to communication than Anglo-Americans.

Responses to questions may be short and long periods of silence may mark the exchange.

Knowing this aspect of culture, the nurse can become more comfortable with periods of silence without pressuring the patient to formulate an answer or assuming that he or she is uninterested.”

— US Healthcare practitioner



“ I think that part of the success, and part of what's important is the power of listening to people's stories. We've set up several virtual forums where somebody would just tell their story. One of my senior Black colleagues told the story of how she went to the chemist and noticed that all the Black hair products had security tags on them. None of the white hair products had security tags on them.

When you start to put yourself in people's positions, and realise these things are happening every single day to some of the people we work with, and they have to come to work to deliver an intervention or attend meetings... In parts of the country where perhaps there isn't a large population of Black or Asian or minority communities, leaders have got particular challenges, because ethnic minority people's concerns could be hidden, and marginalised, so it's even harder in some ways to think about it and understand it.”

— Navina Evans, HEALTH EDUCATION ENGLAND

# FINAL TAKEAWAYS

- **This process is cyclical and ongoing. Just as how culture and language generally shifts over time, the same is true for all diverse cultures.**
- **Though there is a lot to learn, the practice of being culturally sensitive can be a very enriching and rewarding experience.**
- **Don't be afraid to ask questions when in doubt.**
- **Always demonstrate awareness of our own limitations or assumptions. This can be very reassuring and trust-building if communicated with sensitivity and respect.**
- **Remember, nobody expects perfect interactions. Being willing to listen and learn goes a long way to making patients feel respected and centred.**

You need time; you need time to understand people. It's time in experience, and time in knowledge, and time in being able to read them as well. And time to connect with them. So it can't be taught from an article, or a lecture, or a workshop, or from sitting with a patient for the first consultation. It just takes time and different levels, if you know what I mean.

GP, Australia

Let's not forget the NHS values and its reason for being is about providing care for all regardless of wealth or class... I know there is huge uncertainty in the world: the EU exit, COVID, global recession, climate change – things feel pretty hostile at the moment but we need to make time for this as well, both from the perspective of being an employer in the NHS and local authority but also from the provider of care perspective.

Richard Mitchell - SHERWOOD  
FOREST HOSPITALS NHS  
FOUNDATION TRUST



# THANK YOU

For further questions on anything in this resource,  
please feel free to get in touch!

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# ADDITIONAL BOOKS AND RESOURCES

- 'Minor Feelings' by Cathy Park Hong
  - 'The Joy Luck Club' by Amy Tan
  - 'Lost for Words' by Elizabeth Lutzeier
  - 'The Young Atheist's Handbook' by Alom Shaha
  - 'Diversity & Cultural Awareness in Nursing Practice'
- 
- [Culturally Diverse Children's Books](#)
- 
- [Mental Health Glossary](#)
  - [Simplified and Traditional Chinese](#)

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