Title page

Nursing Education to enhance Culturally and Linguistically Diverse (CALD) community access to mental health services: A scoping review

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Abstract:

Research has found that training health care professionals can enhance the access of the culturally diverse community to appropriate mental health services. Yet, little research has been conducted that explicitly focuses on improving nursing knowledge, attitude, and skills that can enhance the access of the CALD community. This scoping review aims to locate, summarize, and recap what is known in the academic literature about educational interventions and programs to improve mental health nurses' cultural competence. Examining how mental health nurses' knowledge, skills, and attitudes can be improved by educational intervention and programs to facilitate Culturally and Linguistically Diverse (CALD) community access to mental health services can also identify gaps in knowledge inform future research areas. Fifteen studies reported a positive effect on the cultural competence interventions; however, it was difficult to establish a single effective intervention method due to the significant heterogeneicity in cultural competence intervention strategies. Most studies in this scoping review included nurses as participants, but only one study focussed exclusively on cultural competence intervention for mental health nurses. Henceforth, there is a prerequisite for more research focussing on enhancing mental health nurses' cultural competency. Additional research is required to evaluate educational interventions' impact on improving cultural competence attributes on specific practitioner behaviours and the effects on health care and health care outcomes. This review can form a basis for future research studies that will emphasise the influence of cultural competence interventions for mental health nurses.

Nursing Education to enhance Culturally and Linguistically Diverse (CALD) community access to mental health services: A scoping review

Introduction:

Australia is known globally as a multicultural country, especially the state of Victoria (Victorian Multicultural Commission, 2015; Australian Bureau of Statistics, 2019). Data from Australian Bureau of Statistics (ABS) 2011 census indicates that Australians originate from 300 descendants and 20 percent speak a language other than English (Department of Health & Human Services, 2016).Research from Australia and overseas shows that the immigrant and refugee population are at a high risk of mental illness. These could be due to several pre -and post-migration factors. These factors include wars, traumatic events such as violence, sexual assaults, famine droughts, pre-existing mental health issues, exposure to cultural shock, adjustment issues, the stress of acculturation, lack of understanding of the health system, and experiences of racism and discrimination (Bhugra et al., 2011).

Despite the prevalence of mental health issues, people with culturally diverse backgrounds (CALD) are uncomfortable with the Western practice of seeking medical treatment(Pedersen et al., 2015; Omar et al., 2015; Na et al., 2016; Im et al., 2017). In particular, they find it strange and threatening to seek services from monocultural Anglo-Celtic healthcare settings (Gopalkrishnan, 2018; Minas, 2018; Moss et al., 2019; Idemudia & Boehnke, 2020). This is due to several factors: a lack of awareness of appropriate services, language barriers, unwillingness to self-disclose to a stranger in a foreign, mistrust, negative myths about mental health services, different cultural views and explanatory models of mental illness, privacy issues, the impact of stigma, hesitancy to seek out support outside immediate social networks and social withdrawal (Cross & Bloomer, 2010; Diversity Health Institute, 2011; Giacco et al., 2014). These concerns often lead to a paradoxical reduction in help-seeking behaviour—i.e., the unwillingness to seek medical help when it is needed.

Many in the CALD community clearly need mental health services. The incidence of mental health problems among the CALD community is estimated to be the same—if not higher—as that of the general community. Statistics by the Commonwealth Department of Health and Aged care 2004 (Department of Health & Ageing, 2004) states that over 250,000 first-generation migrants from CALD backgrounds are estimated to have experienced mental illness in a year. However, reduced help-seeking behaviour prevents assistance from being sought for mental health conditions. Reduced help-seeking behaviour results from cultural beliefs about mental health issues and how people should respond to such illnesses (Cross & Bloomer, 2010; Cross & Singh, 2012). For instance, some cultures may attribute mental illnesses to social, religious, and cultural beliefs. Consequently, they may seek help for such issues from a faith leader or from traditional medicine (Singleton & Krause, 2009; Yang & Hwang, 2016; Horky et al., 2017). They might also deny the existence of mental health conditions(Kirmayer & Guzder, 2014; Torres Stone et al., 2020). Cultural beliefs about the reasons for mental illness influences how the CALD community acknowledges these conditions and affects how they display suffering, describe symptoms, seek help, and access health services(Kirmayer et al., 2011; Minas & Silove, 2013; Im et al., 2017; van der Boor & White, 2020). This situation is inequitable. Evidence has shown that CALD communities do not receive access to mental health services despite these services being widely available (Cross & Singh, 2012; Rooney et al., 2014). There continue to be gaps in health care access and disparities in terms of mental health treatment (Forrest, 2018; Torres Stone et al., 2020). The issue remains about how to address this problem.

Several researchers have noted that health professionals' cultural competence can reduce health disparities (Betancourt et al., 2014; Truong et al., 2014; Jongen et al., 2018;

Oikarainen et al., 2019). Cultural competence training has been identified as the practical approach to advance skills in the cultural responsiveness of the health workforce (Campinha-Bacote, 2002; Munoz et al., 2009; Musolino et al., 2010; Montenery et al., 2013; Aggarwal et al., 2016; Harkess & Kaddoura, 2016; Shepherd et al., 2019; Wamwayi et al., 2019). It has been widely acknowledged that reinforcing the cultural responsiveness of the mental health workforce is crucial to provide culturally appropriate services (Munoz et al., 2009; Henderson et al., 2011; Gill & Babacan, 2012; Davis & Smith, 2013; Alfred et al., 2016; Kirmayer & Jarvis, 2019). This can be attained by building skills and knowledge in cultural competency and evidence-based practice (Cleary et al., 2011; Kirmayer, 2012; Prescott-Clements et al., 2013; Govere & Govere, 2016).

Research also evidences that the improvement in nursing professionals' knowledge of mental health service delivery and cultural responsiveness will result in the enhancement of mental health services access of the CALD communities (Aguiar et al., 2012; Bennett, 2013; McDonough et al., 2013; Betancourt et al., 2014; Owiti et al., 2014; Truong et al., 2014; Kverno, 2016; Santhanam-Martin et al., 2017; Jongen et al., 2018). Numerous recommendations that identifying gaps in education needs through research, developing workforce training, promoting frameworks, and supporting the mental health workforce via academic partnerships, ongoing research, and field education will help to achieve cultural competence in health professionals has been made (Mental Health in Multicultural Australia, 2014; Victorian Multicultural Commission, 2015; The State of Victoria Department of Premier and Cabinet, 2017).

Another significant concern regarding patient safety and healthcare outcomes in delivering care to a culturally diverse community is the potential for miscommunication. Significant communication barriers such as language and cultural differences can seriously hamper the diagnostic and caring process, even if "appropriate diagnoses and treatments are accessed" by the culturally diverse community (Nkanunye & Obiechina, 2017). The medical model's emphasis is on solving problems and monitoring symptoms, and the practice of mental healthcare has been designed accordingly. The traditional medical model has a strong influence on the perceptions of the role of nurses, nursing interventions, and the role of mental health service (Bennetts et al., 2011). Mental health nurses are widely acknowledged as the doorkeepers of many mental health services, and they care for consumers24/7(Marla et al., 2013; Ellis & Alexander, 2016; Crawford, Candlin, et al., 2017). The lack of communication between nurses and clients and the lack of nurses' cultural sensitivity has led to many concerns. This has limited the quality of care provided to the clients from various non-dominant cultures and has also restricted healthcare professionals' opportunities to enhance their knowledge and skill base by learning from those cultures (Cicolini et al., 2015; Crawford, Roger, et al., 2017).

The Victorian Government Cultural Responsiveness Framework: Guidelines for Victorian health service(Department of Health, 2009, p. 12) describes cultural responsiveness as the capacity to respond to the health issues of culturally diverse communities, and this necessitates capability and knowledge at various points of involvement such as systematic, organizational, professional as well as the individual level. Besides, it may be considered an approach to making the service delivery cost-effective by developing associations between

access, equity, quality, and safety, thereby delivering better health care outcomes for culturally diverse consumers (Department of Health, 2009, p.13).

The Federation of Ethnic Communities report (2019, p.1) explains cultural competency "as the ability to comprehend, effectively communicate, and interact across cultures." It is frequently described as "a set of consistent behaviours, attitudes, and policies that are cohesive in an organisation or among professionals and empower them to work efficiently and effectively in cross-cultural situations" (Federation of Ethnic Communities' Councils of Australia, 2019). Cultural competency is closely related to concepts such as intercultural competence (Munoz et al., 2009; Blasco et al., 2012; Sairanen et al., 2013; Fleckman et al., 2015), intercultural sensitivity (Munoz et al., 2009; Guo-Ming, 2010; Lin et al., 2017), cross-cultural sensitivity (Cross & Bloomer, 2010; Chang et al., 2013; Giacco et al., 2014; Rosenbusch, 2014; Nichols et al., 2015; Horky et al., 2017) and cultural humility (Clark et al., 2011; Isaacson, 2014; Foronda et al., 2016).

The three cultural competency training types as described by Coronado (2013): 1. knowledge-based training '(categorical/multicultural approach)' focusing on information about the culture and associated ideas (Prescott-Clements et al., 2013), social factors of health, and distinctions in disease, incidence, and prevalence (Allen et al., 2013; Thackrah & Thompson, 2013). Even though these programs tend to identify patient – healthcare worker relationships and health care outcomes, they have been too population-specific and hence undergoing criticisms, reinforcing widely different categories and lack of precise intersection between health and culture (Williamson & Harrison, 2010; Isaacson, 2014); 2. attitude-based training (cultural awareness/sensitivity approach) which focuses on improving awareness on the influence of socio-cultural factors (Caperchione et al., 2011) on the value and behaviors

of patients and how these factors may ultimately inspire clinical outcomes (Galanti, 2012; Giacco et al., 2014; Valibhoy et al., 2017; Markey et al., 2018; Oikarainen et al., 2019) and 3. skill-based training (cross-cultural method) which highlights gaining communication skills, such as prompting the patient, reporting of patient's ailments and assistance of a cultural liaison or interpreter. These skills help the health care worker negotiate the patient's input in decision and treatment (Marla et al., 2013; Berger & Peerson, 2015; Shepherd et al., 2019).

According to Coronado (2013), the three stages of cultural competency in health care delivery are organisational, systemic, as well as clinical. Many researchers recommend that cultural competency training for the professional development of health care providers at all levels is vital and serves as a cohesive component of the training (Jongen et al., 2018; Oikarainen et al., 2019). Mollah et al. (2018) also reiterate that all health professionals require extensive cultural competence training. Simultaneously, such training must suit the needs of diverse occupations, different health environments, and other practice settings, including urban or rural. Hence, a "one-size-fits-all" model is less likely to function (Oikarainen et al., 2019).

Other foci is, cultural competency in the healthcare system should include: (1) use of interpreters (Klimidis & Minas, 2010; Berger & Peerson, 2015; Shepherd et al., 2019); (2) recruitment and retention multicultural staff (Happell & Gough, 2009); (3) training programs to initiate changes in staff behaviour and staff- patient communications by enhancing cultural responsiveness, knowledge and skills (Starr & C.Wallace, 2009; Dias et al., 2012; Chang et al., 2013; Cicolini et al., 2015); (4) use of community health workers (McGrath & Ka'ili, 2010; Henderson & Kendall, 2011; Usher et al., 2014); (5) cultural competent health promotion (Wand, 2011; Aguiar et al., 2012; Lood et al., 2015; Nkanunye & Obiechina, 2017); (6) involving

family or community members in decision making (Bennetts et al., 2011; Kirmayer, 2012; Olasoji et al., 2017); (7) eliminating ethnocentrism by integrating cultural beliefs into health care practises and thereby increasing cultural awareness (Almutairi et al., 2017; Young et al., 2017); (8) organisational and administrative malleability in health systems (Betancourt et al., 2014; Mollah et al., 2018; Grandpierre et al., 2018; Shepherd et al., 2019).

While evidence suggests that cultural competence training could enhance physicians' attitudes, skills and knowledge, skills, and ratings of care by the patient, there has been no definite link between practice to improved health care outcomes (Betancourt & Green, 2010). However, Brunett and Shingles (2018) conclude in their critical appraisal that patient satisfaction and experiences can be affected by healthcare professionals' cultural competence. A wide range of substantial research has also verified that cross-cultural training enhances health care workers' cultural sensitivity (Stolk et al., 2011; Powell Sears, 2012; Chang et al., 2013; Govere & Govere, 2016). These studies focus on health care workers and students, with a few focusing on nurses and nursing faculty. However, very few studies overtly emphasise mental health nurses' cultural competence and training outcomes.

Objectives:

This scoping review aimed to uncover and summarize what has been identified in the academic literature about educational interventions and programs to improve mental health nurses' cultural competence. Examining how mental health nurses' knowledge, skills, and attitudes can be improved by educational intervention and programs to facilitate CALD community access to mental health services may as well recognise gaps in knowledge and identify future research areas.

Methods: This scoping review was performed to chart the research activities and recognise gaps in the literature regarding educational interventions and programs improving mental health nurses' cultural competence. When little research exists, researchers are motivated to undertake scoping reviews, to include systematic mapping, synthesising, and summarising the extensive knowledge base on a particular topic (Arksey & O'Malley, 2005; Levac et al., 2010). According to (Levac et al., 2010), a scoping review can be considered as a combination process used to comprehend or plot the main ideas to disseminate the extent and depth of a specific field. The scoping review methodological framework recommended by Arksey and O'Malley (2005) guided and informed this study. Arksey and O'Malley described that the scoping review could be performed as a five-step method (Arksey and O'Malley, 2005) and, the updates by Levac (Levac et al., 2010) were used as a template for this review. The five steps involved are: "*(i) Identifying the research question (ii) identifying relevant literature (iii) selecting studies (iv)charting studies and (v)collating, summarising, and reporting the results" (Arksey & O'Malley, 2005).*

a. Identifying the research question

This scoping review's research questions were developed to recognise a broad literature range (Arksey & O'Malley, 2005).

- 1. What does the academic literature says about educational interventions and programs to improve mental health nurses' cultural competence?
- 2. If cultural competence training produces a measurable change in knowledge and skills of mental health nurses relating to the care of consumers from diverse cultural and ethnic backgrounds?

b. Identifying relevant studies:

The key terms in this study with a narrow focus were "*culturally and linguistically diverse community/ English as second language /refugee/migrant, health care utilization, access to mental health services, psychiatric /mental health nurse education, health care worker, cross-cultural training/transcultural training/ cultural competence education.*" Truncated words and terms with the same root words were included to broaden the search by creating 'Boolean' strings.

Six databases were searched, including CINHAL, MEDLINE, PsycINFO, Web of Science, SCOPUS, and Google Scholar, to be comprehensive and cover the whole subject area. These databases were selected to be broad and inclusive of the entire subject area. An extensive search of databases for peer-reviewed studies published between January 2009 and March 2020 and primary and secondary articles was conducted. Some papers were hand-searched from the references of selected studies. Three independent researchers examined the data from selected papers and abstracts through a prescribed protocol of data charting and critical analysis by the Joanna Briggs Institute (Joanna Briggs Institute, 2014). Furthermore, the research team manually searched the reference lists of all qualified studies. The team developed inclusion and exclusion criteria using PICO format, in line with Arksey and O'Malley's (2005) methodology, and these are presented in Table 1. *(Table1. Inclusion and exclusion criteria).*

The inclusion criteria were; original and peer-reviewed journal articles available in the English language, psychiatric/mental health/ nurse education, cross-cultural training/transcultural training/ cultural competence education in the title, keywords,

abstract, or main body were included. Inclusion criteria also included full-text studies. Studies were disregarded if they did not meet the inclusion criteria. Conference abstracts, systematic reviews, and news /magazine articles were also omitted. Since the study focused on nurses' educational interventions to support CALD communities, sources that examined the Aboriginal community were not included as that community has specific needs. Finally, sources were excluded that focused on nursing student education on cultural competence.

c. Study selection

The search results were sieved using a three-step approach: (i) Title search to eliminate duplicates and extraneous articles (ii) Full texts of the remaining articles were scrutinised, and abstracts were reviewed and (iii) A manual search of all the reference lists of the related articles to find further citations. A primary database search yielded 340 sources. A total of 188 articles remained once the duplicates were removed. Endnote TM database was used to download eligible studies, and the internal and external duplicates were recognized and removed. A collaborating team approach was used in all phases of data extraction, and Joanna Briggs Institute's (JBI) critical analysis tool was used for the review of the relevant studies. All papers nominated for inclusion in the scoping review were subjected to assessment by two critical appraisers (RR and LT). All divergences concerning the studies' methodological classification included were discussed and approved by a third reviewer (WMC). The two team members (RR and LT) independently reviewed each title and abstract, using the inclusion criteria. Following this, the sample was made free of the articles which did not satisfy the inclusion criteria. The same research team then autonomously reviewed the nominated full-text articles. Any disagreements were resolved through consensus with a third reviewer (WMC). After a full-text appraisal, only eleven studies fulfilled the inclusion criteria.

After performing a manual search of the reference lists, four more sources were identified. *(Figure.1 Prisma diagram)*

d. Charting the studies

As suggested by Arksey and O'Malley (2005), the team used the descriptive and analytical method and charted appropriate evidence that responded well to the review questions from the literature review. The information included: authors, publication year and location, the purpose of the study, study designs, key findings/issues. *(Table 2. Charting the studies)*

e. Collating, summarising, and reporting the results

Arksey and O'Malley (2005) recommended that the fifth step in a scoping review process is to use a systematized narrative format to write the findings and present a brief literature review to answer the research questions. We summarised all the included articles into a report to collate the author, year of publication, journals that published the articles, location, types of articles, and cultural competency education details in the papers reviewed. While charting the reviewed literature's key findings, common themes appeared regarding the educational interventions to enhance the cultural competence of mental health nurses and the measurable cultural competence and skills of mental health nurses. The common themes were grouped across five broad areas*: Identified study designs for cultural competence education, Theoretical frameworks used regarding cultural competency, Cultural competence training characteristics, Measurement of cultural competency, and Effects of cultural competence education.*

Discussion:

Among 15 articles included in the final sample, all utilized methods such as Randomised Control Trial (RCT)s, case studies, and quantitative and qualitative studies. The majority of the studies included were conducted in the United States of America (n=8), and the remaining were undertaken in Australia (n=2), Taiwan (n=1), United Kingdom (n=1), Finland (n=1), Jamaica (n=1), and Sweden (n=1). All the studies counted in were published between 2009-2020. The marked heterogeneity in the study locations indicate the global perspectives of cultural diversity and the emerging recognition of the importance of cultural competencies among health workers.

Identified study designs for cultural competence education:

Of the 15 studies, two adopted the RCT design (Berlin et al., 2010; Lin & Hsu, 2020). A quasi-experimental study design was used in the five studies included (Khanna et al., 2009; McDougle et al., 2010; Palmer et al., 2011; Delgado et al., 2013; Bhat et al., 2015). However, some of the quantitative studies were longitudinal studies (Wilson et al., 2010; Delgado et al., 2013; Bennett, 2013). Another three used a qualitative design (McDonough et al., 2013; Santhanam-Martin et al., 2017; Kaihlanen et al., 2019). Studies by Lange et al. (2013); Owiti et al. (2014); Debiasi and Selleck (2017) used a mixed-method study design.

The longitudinal design used in the studies to evaluate the educational intervention helped to detect changes more precisely than a one-time measure. The variations in the participants' knowledge, skills, and attitudes following the training interventions can also be determined by the longitudinal study design (Oikarainen et al., 2019).

Theoretical frameworks used regarding cultural competency

The cultural competency training modules were created using a wide array of theoretical frameworks. The majority of the studies used a valid and reliable framework for cultural competency training, whereas some studies used evidence-based educational techniques from the literature (Delgado et al., 2013). The Race Equality and Cultural Capability (RECC) training model (Bennett, 2013) focused on improving mental health nurses' knowledge and skills. Some studies (Berlin et al., 2010; Wilson et al., 2010; Lin & Hsu, 2020) used the theoretical models; for instance, the cultural competence model by Campinha-Bacote was employed to inform the design of interventions. Cultural competence, as explained by this model, is a continuing process, including incorporating "cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire" (Campinha-Bacote, 2002; Abitz, 2016). A nursing theory named Leininger's Culture Care Theory (CCT), directed on culture and care relationships, formed the theoretical outline in the study by (Bhat et al., 2015; Abitz, 2016). Besides this, to endorse the cultural competence changes in nurses, Bhat et al. (2015) adopted the "Kurt Lewin's Change Model."

The Purnell Model for Cultural Competence (Debiasi & Selleck, 2017) is inclusive and encompasses many aspects of diversity in its 12 domains. The 'Constructivism learning theory' was the pedagogical approach in the study by Kaihlanen et al. (2019). This theory was chosen as it highlighted the learner's activity and engagement in using participants' own past experiences to enhance their knowledge, develop, understand, and form values. Institute of Medicine (IOM) and Culturally and Linguistically Appropriate Services in Health Care (CLAS)-based cultural competency training program was used in the study by Khanna et al. (2009). Palmer et al. (2011) defined the themes such as "cultural and linguistic capability"; "ethnic and racial health inequalities," "the relationship between culture and health beliefs," and "the

role of cultural competency in enabling effective communication between patients and providers." Palmer et al. (2011) also used "the LEARN communication model (Listen, Explain, Acknowledge, Recommend, Negotiate)," which assisted the health care workers in overcoming communication and cultural barriers to successful patient education. The ASKED model (Lange et al., 2013) is a model developed by Campinha-Bacote, representing the self-analysis questions about participants' awareness,' 'skill,' 'knowledge,' 'encounters' and 'desire.' The "ASKED model" recommends that attaining cultural competency is a process comprising of five essential steps: "developing **A**wareness of differences, acquiring **S**kills to assess those differences, seeking **K**nowledge of other cultures, **E**ngaging with individuals different from oneself, and having the **D**esire to change one's attitudes and beliefs about others" (Lange et al., 2013).

The Transcultural secondary consultation (currently known as Transcultural Clinical Discussion Service) model was used by McDonough et al. (2013); Santhanam-Martin et al. (2017). The Victorian Transcultural Mental Health (VTMH) “framework of recovery principles,” combined with cultural perceptions on medical care, was one of the major elements of secondary consultation. The pilot Transcultural Secondary Consultation Program merged outcomes from a cultural competence training program. Simultaneously, clinicians from the Goulburn Valley Area Mental Health Services (GVAMHS) were encouraged to validate and broaden their knowledge and skills (McDonough et al., 2013). Santhanam-Martin et al. (2017) intended to advance cultural responsiveness and improve cultural awareness capacity in a clinical mental health setting using a ‘secondary consultation’ method. The secondary consultation framework principles recognise cultural standards to be understood in a ‘recovery’ context. The principles also suggest that this recovery needs to occur at the

individual level as ‘symptom recovery,' at the family or community level as ‘social and functional recovery,' and at the systems level as ‘ adherence and relapse' (Santhanam-Martin et al., 2017).

The "**CARE** (Consider, Accept, Recognise, and Execute) model" to build cultural competency in health care was used in the McDougle et al. (2010) study. The principles that form the basis of the CARE model include; "**C**onsider and reflect on the clients' health needs, cultural issues, and concerns; **A**ccept and understand that cultural differences, practices, and perspectives of the clients will impact their health care experience.; **R**ecognise and build familiarity with the cultural norms, beliefs, and attitude of the clients towards health care; **E**xecute a proactive, culturally sensitive health care intervention to support client's recovery and to respect the cultural values provide quality health care and medical treatment" (McDougle et al., 2010). "The Cultural Consultation Service (CCS) model" was formed and executed as a pioneering model by Owiti et al. (2014) as a variation of "the McGill model.” The McGill model uses the 'ethnographic methodology' and 'medical anthropological knowledge’ to broaden the theoretical and dynamic understanding of culture, thereby improving the skills in cultural competency of health care professionals.

The theoretical backgrounds in the studies by Wilson et al. (2010); Delgado et al. (2013) continued as unclear; however, there is some mention of the use of evidence-based educational methods to assist the attainment of "cognitive and affective skills" desirable to attain advanced levels of cultural awareness. These methods were employed as the model for teaching sessions and were obtained from the researchers' literature reviews (Delgado et al., 2013). The fundamental components of cultural competence in the above theoretical

frameworks were found to have many common aims. However, some variances were recognized regarding the focus and context in which they were developed.

Cultural competence training characteristics

The primary intervention in all 15 studies included in the scoping review was the cultural competence training program and employed diverse cultural competence training styles. The educational contents of cultural competence interventions are outlined in Table 3 (*Table 3 -Cultural competency details).* All the educational interventions in the studies included were mainly aimed to encourage understanding ideas such as culture, cultural competence, cultural diversity, cultural awareness, and cultural responsiveness. The cultural competence training program in all the studies focused on the nurses analysing their cultural perspectives, biases and prejudices, cultural traditions, professional context, and the need for multidisciplinary collaboration.

A diverse group of health professional groups participated in the corresponding interventions in the studies reviewed. Nevertheless, there were no apparent differences between the outcomes in the professions. The results showed that the cross-cultural competency training interventions could be beneficial to many other health professions as part of ongoing professional development. The findings of many studies also found that interdisciplinary conversations may be profitable (Khanna et al., 2009; McDougle et al., 2010; Wilson et al., 2010; Palmer et al., 2011; Delgado et al., 2013; Lange et al., 2013; McDonough et al., 2013; Owiti et al., 2014; Santhanam-Martin et al., 2017).

The interventions reviewed were found to be significantly distinct in the delivery mode chosen. Three studies used web-based techniques to deliver the intervention (Palmer et al.,

2011; Bhat et al., 2015; Debiasi & Selleck, 2017). Eight studies used a face to face delivery (Khanna et al., 2009; McDougle et al., 2010; Palmer et al., 2011; Delgado et al., 2013; Lange et al., 2013; Bhat et al., 2015; Kaihlanen et al., 2019; Lin & Hsu, 2020) or clinical practice interventions (Berlin et al., 2010) accompanied the theoretical component of the training; or cultural consultation model (McDonough et al., 2013; Owiti et al., 2014; Santhanam-Martin et al., 2017) to improve the cultural competency. However, the study by Wilson et al. (2010) did not mention the delivery mode of the educational intervention.

A training consultant with a widespread understanding of the topic independently devised the RECC training curriculum for the study by Bennett (2013). The learning resources were formulated with the aid of a skilled reference panel and in close partnership with the consumers. With the assistance of a qualified ethnic minority service user trainer, an independent lead trainer facilitated the training. The cultural competence model and its definitions by Campinha-Bacote (2002) were included in the training devised by Berlin et al. (2010). The training material comprised relevant content knowledge derived from previous research by the principal researcher regarding the nurses' and the parents' problems and apprehensions. Bhat et al. (2015) developed the curriculum as three web-based units uploaded on the organisation's website as the compulsory yearly modules. The detailed information on cultural preferences for palliative care collated from academic programs and literature review by the researchers was rolled out as the self-study curriculum for the participants. Debiasi and Selleck (2017) developed the curriculum, and participants received PowerPoint presentations via emails as learning material. A core group of instructors facilitated the cultural competence training, and the curriculum for the training was developed by the researchers in the study by (Delgado et al., 2013).

In the Kaihlanen et al. (2019) study, an experienced teacher from a multicultural center facilitated the training using the researchers' curriculum. The researchers developed and facilitated the training in the Khanna et al. (2009) study. Applying the feedback from focus groups, two baccalaureate nurses (Lange et al., 2013) prepared the sessions adapting the existing resources from Geriatric education centres, health departments, and cultural centres. The sessions were conducted onsite by two nurses undertaking graduate nursing degrees, and the session plans were advised by an external professional who also presented the interactive activities (Lange et al., 2013).

The education session in (Lin & Hsu, 2020) was facilitated by two lecturers who were Ph.D. Nursing scholars and were also qualified in delivering multicultural competence. Feedback on cultural topics and revision of the course based on feedback from the participants were conducted by three education experts related to the field. The education program's design in (McDonough et al., 2013) was influenced by the critical strategic objectives shared by the Victorian Transcultural Mental Health (VTMH) and Goulburn Valley Area Mental Health Service (GVAMHS). The training sessions were delivered by members of the GVAMH cultural working group and cultural portfolio holders (CPHs).

In contrast, in the transcultural secondary consultation sessions in Santhanam-Martin et al. (2017), CPHs and VTMH lead facilitators were the facilitators for the sessions. In the McDougle et al. (2010) study, the training was devised by different health organizations and consultants. The sessions were facilitated by experienced and qualified health care/human service trainers facilitated the sessions. The training was designed by cultural consultants and care coordinators in Owiti et al. (2014), and the sessions were conducted by mental health clinicians from various ethnicities and diverse professional backgrounds. Palmer et al. (2011)

utilised a storyboard to outline content drafted by the research team. A multimedia company qualified in producing web-based instructional modules was appointed to create the participant interface, graphics, and video. The training sessions were delivered in the form of an interactive web-based CME course. The training was conducted via a cultural competence workshop by Wilson et al. (2010), but no information was available regarding curriculum development. Even though a wide range of intervention types, durations, and methods were used, it was challenging to make a universal statement on the kind of interventions that proved as utmost successful or whether a longer duration or stronger participant involvement was more effective in producing better outcomes. The cross-cultural training approaches in the studies listed in the scoping are outlined in Table.4 *(Table.4 Cultural competence training approaches).*

Measurement of cultural competency:

A wide diversity of evaluation tools was used across the studies to measure cultural competence changes after the educational intervention. The majority of studies estimated the differences in cultural competence using validated instruments. Most studies used subjective assessment methods such as self-rated Likert scales to measure the cross-cultural competency intervention. Two studies Bhat et al. (2015); Debiasi and Selleck (2017), used the Cultural Competence Assessment (CCA) tool by Schim et al. (2003). Debiasi and Selleck (2017) used a Clinician's Cultural Sensitivity Survey using a Cultural Competency Assessment (CCA) tool and five open-ended questions followed by a post-test survey to obtain the results.

In contrast, the research questions were answered using a “triangulated approach,” which included a quasi-experimental pre and post-test design, participant journal, and open-

ended structured interviews in the study by Lange et al. (2013). Khanna et al. (2009) developed a cultural competency assessment tool to measure the study's outcome. Khanna et al. (2009) also adopted a Post (after training) then Pre (before training) evaluation method, and (Palmer et al., 2011) adopted a pre-test, post-test questionnaire along with a 12-point Likert scale to evaluate participant satisfaction with the course and its content. Another two studies (Delgado et al., 2013) used Campinha-Bacote's "Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals- Revised" (IPACC-R), and Wilson et al. (2010) used a survey with the “Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals (IAPCC)” (Campinha-Bacote, 2002). Other studies used valid instruments such as "Race Equality and Cultural Capability" (RECC) by (Bennett, 2013); The "Clinical Cultural Competency Training Questionnaire" pre (CCCTQ-PRE) and the "Clinical Cultural Competency Training Evaluation Questionnaire-post" (CCCTEQ-POST) by (Lange et al., 2013); Nursing Cultural Competence Scale (NCCS) by Lin and Hsu (2020); CARE Training Program Questionnaire by McDougle et al. (2010); and “Tool for Assessing Cultural Competence Training (TACCT),” a self-assessment cultural competence tool by Owiti et al. (2014). The evaluation of the sessions in the studies by (McDonough et al., 2013; Santhanam-Martin et al., 2017) was done collectively by the participant and facilitator feedback.

The instruments used in the studies performed a significant role in gauging the effectiveness of the interventions using self-rated and objective assessments. Researchers have compared the assessment methods of cultural competency and found that self - evaluations of cultural competence are more comfortable to conduct, even though the objective methods could benefit cultural competency research. However, the accuracy of self-evaluation is not always constant with observed behaviours over a long-term period.

Assessing nurses' cultural competency using validated instruments can facilitate comparability across studies and in different settings (Oikarainen et al., 2019).

Effects of cultural competence education:

All studies verified a positive effect on the improvement in cultural competency. Five studies (Berlin et al., 2010; Delgado et al., 2013; Lange et al., 2013; Debiasi & Selleck, 2017; Lin & Hsu, 2020) reported improved patient outcomes and reduced health disparities as a result of the increase in cultural competency knowledge. Others described enhanced knowledge, skills, and nurses' attitudes (McDougle et al., 2010; Wilson et al., 2010; Bennett, 2013; Bhat et al., 2015; Kaihlanen et al., 2019). However, Bennett (2013) revealed that the longitudinal investigation of knowledge and skills changes was not constant over time. Four studies reported improved cross-cultural care and promoted significant cultural encounters (Khanna et al., 2009; McDonough et al., 2013; Owiti et al., 2014; Santhanam-Martin et al., 2017). The teaching methods varied from lectures, group discussions, workshops, self-reflections, role play, case studies, case reports, clinical case presentations, and clinical practice. While cultural simulation for a brief period was used as a training strategy (Delgado et al., 2013); storytelling was used by Lin & Hsu (2020), the cultural consultation model by Owiti et al. (2014), and transcultural secondary consultations by McDonough et al. (2013) and Santhanam-Martin et al. (2017).

There was heterogeneity in curriculum duration and the study period, which was unclear in some studies. However, the study modules ranged from 20 minutes (Bhat et al., 2015) to 90 minutes (Santhanam-Martin et al., 2017), and the study duration from 3 months (Bennett, 2013) to 6 years (Lange et al., 2013). The findings of these studies propose that

significant conclusions have resulted from long-term interventions compared to short -term interventions. However, the number of participants in each training session was not stated. Hence, it is impossible to assume whether the study's duration is the primary influence on its efficacy.

This scoping review identified that cultural competence is a stringent process that requires a constant obligation by the nurses to attain the capacity to function efficiently in a culturally diverse setting. This review aims to find evidence for educational interventions and programs to advance the cultural competence of mental health nurses. A substantial inconsistency and heterogeneity were noted amongst the studies in regards to the study designs, participants of the study, types of educational interventions, trainee, trainer, and organisational characteristics, theoretical frameworks, delivery of interventions, the period of the interventions, the level of follow-up and in the usage of various measuring instruments for the cultural competency outcomes. From the fifteen studies that were reviewed, the majority reported that educational interventions had positive results and statistically significant self-measured changes in the cultural competence of nurses. This review specified the components of interventions, investigated the theoretical context, educational content, and delivery of the education rather than merely focusing on the effect of the intervention. Although the results are favourable, the review could not find exactly which aspects of cultural competence education contributes towards positive outcomes.

Many researchers recommended a practical approach to minimising health disparities, enhancing consumer access to health care services, and providing satisfaction with cultural competency training. Most studies reviewed suggest that training programs improved the “knowledge, attitudes, and skills” of health care workers. However, a few

studies linked improved health outcomes to cultural competency training (Berlin et al., 2010; Delgado et al., 2013; Lange et al., 2013; Debiasi & Selleck, 2017; Lin & Hsu, 2020). The outcomes of this scoping review suggest that cross-cultural competencies can be imparted successfully using educational interventions that do not offer separate racial or social groups. Theoretical frameworks can evaluate the studies focused on prior experiences or ongoing cultural competence improvement through life experiences. The diversity of interventional approaches adopted to advance the cultural competence of the health workforce across developed and developing countries can be observed as the significance of our study. Henceforth, (Jongen et al., 2018) emphasised that a diversity of approaches could be used to enhance the health workforce's cultural competence, and this ongoing process can be facilitated by utilizing all the available opportunities. However, the wide variance in theoretical frameworks, intervention approaches, and outcome measures makes it difficult to ascertain "the kind of effective cultural competence mediations, for whom, in what setting, and why?"; it remains unidentified (Oikarainen et al., 2019). It can be claimed that cultural competency is a dynamic process that is conditional and circumstantial and hence cannot be perceived as an end-stage, but rather as a repetitive process to ensure subtle, autonomous, and impartial modification of practices (Walker et al., 2014). The cultural training approaches are listed in Table 4 *(Table 4.Cultural training approaches).*

The majority of cultural competence education in the reviewed studies used traditional contact teaching, and some were delivered using technology-based teaching approaches. Online or distance learning can be a learning platform for current and future nurses. It overcomes language barriers and provides a tailored, subliminal, and smooth learning process with advancements in computer and information technologies. Despite

some apparent advantages of online learning, it can also be an effective strategy to overcome crises like the COVID-19 pandemic, where participants can adhere to the respective crisis management guidelines.

Gaps in the research

This scoping review reported numerous gaps in the current literature regarding educational interventions and programs to improve mental health nurses' cultural competence- knowledge, skills, and attitudes. Many studies had small sample sizes, and hence there are concerns about the generalization of the results. The concerns regarding participant characteristics, such as their professional settings, years of experience and characteristics of their workplace, the suitability of interventions for the target population, and lower representation of mental health nurses due to small sample sizes remain. The studies included in this scoping review measured the cultural self-efficacy of professionals or self-evaluation of cultural competence. Hence there is a possibility that a most accurate answer will not be obtained as the individuals tend to report what is more socially acceptable to them.

The unhinged study designs, selection bias, higher rates of participant attrition, lower response rates, short time or absence of follow-up after training, lack of a control group, and lack of methods that endorse and uphold meaningful cultural behaviour change were some of the operational issues identified. Moreover, there is a scarcity and inconsistency in innovative approaches to examine cultural competency training outcomes and evaluate learning cultural competence models. The Cost-effectiveness of the training programs is another issue to be addressed. The issues such as lack of objective measurement of the

acquired knowledge and skills levels, lack of time to practice attained skills and display the capabilities, lack of organizational support to design and implement training were the other gaps found by this review. Only a single study was acknowledged as appraising the efficacy of cultural competence education exclusively for mental health nurses; however, the study setting was not reported.

Limitations

All those publications included in this scoping review were identified using the search strategy of clinical databases and google scholar. A few were hand searched. However, there may be a possibility that some relevant publications may not have been found or omitted by accident during the initial stage of reviewing titles and abstracts. The studies where the educational interventions are not cited in the title may also have excluded. Based on the inclusion criteria, only peer-reviewed articles in English were selected, which could be another limitation of the study. We excluded the grey literature that included non-peer-reviewed publications or documents/reports produced on all governments and academics levels and hence may have missed some eligible studies.

Even though the term ‘Culturally and Linguistically Diverse’ background includes people from indigenous and immigrant backgrounds, this scoping review did not include the articles related to the indigenous population. The studies' heterogeneity made it challenging to entice any firm conclusion about intervention type and the related outcomes. However, the heterogeneity of research aims, interventions, and results confirmed that a series of methods could be adopted to enhance healthcare workers' cultural competence. Many studies intended to advance the cultural competence of the health workers and included

nurses as participants. Nevertheless, very few studies had cultural competence interventions aimed at mental health nurses. This review only included studies that overtly focussed on improving the health workforce's cultural competence, where nurses were part of the sample. As a result, the studies that covertly aimed to increase cultural competence and any studies that focussed on the health workforce other than nurses may have omitted. Our team did not perform a systematic literature review on educational methods to advance cultural competence. Consequently, we are unable to come to conclusions about the quality of studies applying the educational interventions.

Conclusion

This scoping review aimed to comprehend the educational interventions and programs to enhance mental health nurses' cultural competence and identify if the training produced a measurable modification in mental health nurses' knowledge and skills for providing quality care for consumers from various cultural and ethnic backgrounds. While reviewing the 15 studies, it was noted that all the studies reported cultural competency interventions and their outcomes for the health workforce though only one study reported changes in knowledge, skills, and attitudes via cultural competency training of mental health nurses. Hence, reflecting on our research question, we can conclude a lack of empirical data. With the rapid growth in the multicultural population and nurses being the doorkeepers of many health services, nurses' cultural competence must be enhanced to facilitate the culturally and linguistically diverse community access to appropriate health services. A wide range of methods to assess cultural competence and intervention approaches recognized to be effective in improving competence needs to be initiated to enable a culturally congruent nursing practice.

The shortage of evidence on a single effective strategy for teaching cultural competence continues. Further research is essential to appraise the influence of educational interventions to enhance cultural competence attributes on specific practitioner behaviors and the effect on health care outcomes. This review can form a foundation for future research studies that will emphasize the influence of cultural competence interventions on mental health nurses.

Relevance for clinical practice:

The knowledge, confidence, and competence of mental health nurses regarding consumers' needs from a CALD background can be improved through cultural competence training. Besides, consumers will be able to look forward with hope and start taking steps towards recovery by choosing appropriate services with the assistance of culturally competent nurses. Thus, the consumers will receive a culturally relevant mental health service experience, service access, and satisfaction into the future.

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Fig: 1- PRISMA- flow diagram

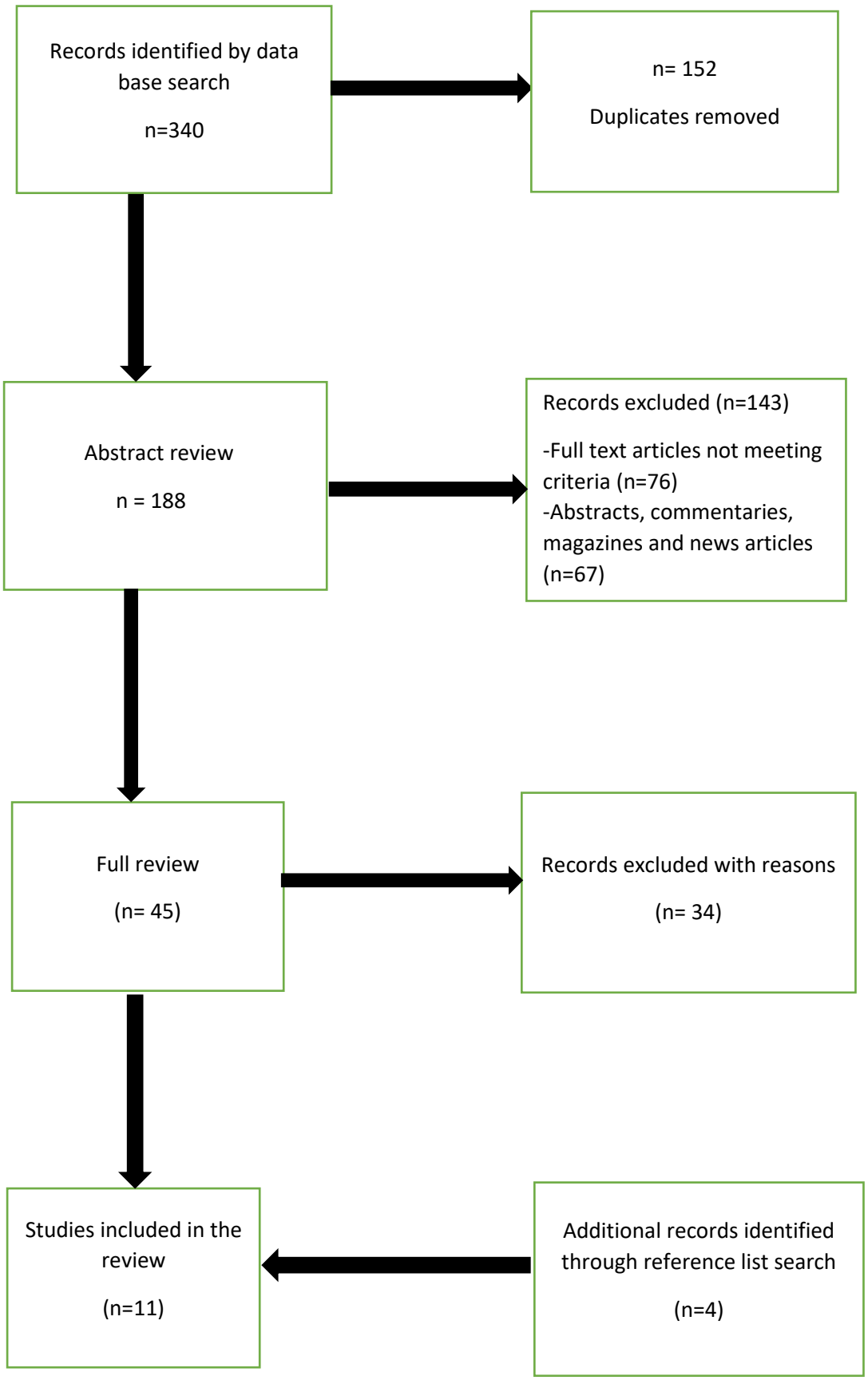

Table 1. Inclusion and exclusion criteria

Criteria	Inclusion	Exclusion
Population	Studies comprised of nurses, nurse practitioners or nursing faculty. Showed no specification to one particular cultural group or disease	Studies comprised of participants who are not nurses or, nursing students being the participants. Sources that included Indigenous community were excluded.
Interventions	Actual interventions that aimed to increase cultural competencies	Non- educational interventions, interventions not aimed at improving cultural competency
Comparators	Standard practice, alternative intervention, no comparator	
Outcomes	Evaluation of Cultural competence education/training Cultural competence assessments by nurses	Not relevant to cultural competence Outcomes measured for other health care workers and not nurses.
Study designs	RCTs, Quasi-experimental studies, Quantitative and Qualitative studies.	Systematic/ literature review, conference abstracts, news articles
Publication type	Peer -reviewed original studies	Non- peer reviewed studies
Publication years	Jan 2009 - March 2020	Pre 2009
Language	English	Language other than English

Table 2. Charting the studies

Author (Year)	Publication/ Location	Purpose of the study	Study design	Key findings/ Issues
Bennett, J. (2013)	International Journal of Culture and Mental Health (Jamaica)	To evaluate the RECC training program's effectiveness by comparing training participants' ratings of knowledge and skills in race equality and cultural competence before and after training.	Longitudinal design	The Race Equality and Cultural Competency training resulted in a significant improvement in knowledge and skills immediately post-training.
Berlin et al. (2010)	Nursing and Health Sciences (Sweden)	This study aimed to evaluate the extent to which specific training affected how nurses rated their cultural competence, difficulties, and concerns and to study how the nurses evaluated the training	Randomised Control Trial (RCT)	Improved cultural competence, positive effects on the nurses' working conditions as they felt more skilled and confident when dealing with cross-cultural encounters and situations in the health services.
Bhat et al. (2015)	Journal of Hospice & Palliative Nursing (US)	The purpose was to determine if registered nurses (RNs) working in a combined palliative care and hospice (PCH) unit had increased cultural awareness, sensitivity, and culturally competent behaviours after completing an intervention consisting of 3 Web-based cultural education modules. The second purpose was to ascertain if the intervention improved the RNs' cultural assessment documentation.	Quasi-experimental Design	Results showed this study's Web-based learning increased cultural awareness, sensitivity, and caring behaviours.
Debiasi & Selleck (2017)	Journal of Cultural diversity (US)	To determine whether cultural competency training improved NPs' ability to provide culturally competent care, as evidenced by NP self-reports and client assessments.	Mixed - methods	Cultural competence training for NP's has potential to increase appropriate care and improve client satisfaction
Delgado et al. (2013)	Journal of Transcultural Nursing (US)	To estimate and compare self–reported cultural competence of nurses and to assess the impact of the training on the nurses' cultural competence.	Quasi-experimental Design	The study demonstrates that providing cultural competence education to nurses may better equip them to care for patients from diverse cultures.

Kaihlanen et al. (2019)	BMC Nursing (Finland)	This study examines the perceptions of nurses about the content and utility of cultural competence training that focuses on increasing awareness of one's own cultural features.	Qualitative	The results of this study indicate that increasing awareness of one's own cultural features can be useful for easing cross-cultural encounters in a healthcare setting and improving the cultural competence of nurses.
Khanna et al. (2009)	The Journal of National Medical Association (US)	The purpose of our study was to assess change in participants' knowledge and skills related to cultural competency in response to our training.	Quasi-experimental Design	The study findings suggest that there is a statistically significant change in participants' self-report of knowledge and skills related to cultural competency
Lange et al. (2013)	Applied Nursing Research (US)	This study aimed to improve communication and care provision in five home or long-term care settings by raising staff awareness about health beliefs and patterns among varied cultures	Mixed - methods	Comparison of pre and post cultural self -efficacy scores revealed that participant confidence regarding their knowledge and skills when interacting with other cultures improved interactions with patients and co-workers.
Lin & Hsu (2020)	Nurse Education Today (Taiwan)	To investigate the effect of a cultural competence educational course on nurses' self-assessment of their cultural competence.	Randomised Control Trial (RCT)	Educational programs on cultural competence effectively improved cultural competence in clinical nurses.
McDonough et al. (2013)	Australasian Psychiatry (Australia)	The Pilot Transcultural Secondary Consultation Program aimed to provide clinicians from VTMH and GVAMHS with opportunities to have conversations about ways to approach the care and treatment of individuals and their families that take cultural and social considerations into account.	Qualitative	The study demonstrates a secondary consultation model as an approach for developing and improving awareness of cultural factors, served as a forum in which to reflect on cross-cultural mental health issues, and for discussing how practice, organisational and, community-based factors influence the way particular individuals' access and utilize services.
McDougle et al. (2010)	Journal of the National Medical Association (US)	The aim of the study was to report the educational outcomes of the newly developed CARE (Cultural Awareness and Respect Through Education) Columbus cultural competency training program.	Quasi-experimental Design	CARE Columbus cultural competency training program appears to demonstrate its effectiveness in improving attitudes, knowledge, and skills.
Owiti et al. (2014)	Journal of Psychiatric and Mental Health Nursing (UK)	To establish that a cultural consultation model will improve patients' outcomes and clinicians' cultural competence skills.	Mixed- method	The study indicated that cultural consultation model is an innovative way of training clinicians in cultural competence skills through a dynamic interactive process of learning within real clinical encounters.

Palmer et.al (2011)	BMC Medical Education (US)	To develop and evaluate a continuing medical education (CME) course to improve healthcare provider knowledge about breast cancer health disparities and the importance of cross-cultural communication in provider-patient interactions about breast cancer screening.	Quasi-experimental Design	Findings suggest that using a web-based CME course to educate healthcare providers about breast cancer disparities and the importance of cross-cultural communication was effective in changing intermediate outcomes.
Santhanam-Martin et al. (2017)	Transcultural Psychiatry (Australia)	The transcultural secondary consultation model aims to enhance cultural responsiveness in partnership with mental health services.	Qualitative	The results of the transcultural secondary consultation model emphasize the need for multidisciplinary collaboration and a facilitated space to explore culturally responsive therapeutic practices.
Wilson et al. (2010)	Journal of Cultural Diversity (US)	To measure the process of cultural competence over time in a group of Health Science faculty teaching nursing and other allied health students.	Longitudinal design	The results of the study demonstrate that developing cultural competence is a continual growth process that individuals experience over time, and individuals may move between the stages of cultural competence.

Table.3 Cultural competency training details in the review articles

Author (year)	Learner (n= no: of nurses) & Study Site characteristics	Theory in curriculum	Curriculum /Learning material developer	Training facilitator	Teaching methods	Mode of delivery	Duration of curriculum	Study duration	Measurement of cultural competency
Bennett, J. (2013)	51mental health staff n=31 Mental Health nurse (including nurse mangers) site not reported	Race Equality and Cultural Capability (RECC)	RECC training by an independent training consultant, learning materials by an expert reference panel	Independent lead trainer with a trained ethnic minority service user trainer in support.	presentations, discussion, group work and case analysis	Face to face	12 sessions x 5 days	3 months	Survey questionnaire developed from the same conceptual model of RECC program
Berlin *et al.* (2010)	Intervention group (n = 24) nurses; Control group (n = 27) nurses Primary child health -care centres	Theory of cultural competence by Campinha-Bacote	Campinha-Bacote cultural competence model and from previous researches by the researchers.	Researchers	Participatory learning approach focused on nurse's clinical work, theoretical and clinical/practice section, case methodology, reflective practice group	Face to face	3 days of training	4weeks	The Clinical Cultural Competence Training Questionnaire pre-& post (CCCTQ-PRE) & (CCCTEQ-POST)
Bhat et al. (2015)	n=15 nurses Palliative care and Hospice (PCH) units at a Hospital	Leininger's Culture Care Theory (CCT) & Kurt Lewin's 3-stage change theory	By the lead researcher	Self – study by participants	3 Web- based cultural education modules as mandatory annual modules	Online	20 mins x 3 weeks	9 weeks	Cultural Competence Assessment (CCA) tool
Debiasi & Selleck (2017)	n= 13 nurse practitioners	Based on the Purnell Model for Cultural Competence	Researchers	Self-study by participants using power points sent in email.	Power points - reflection questions, case studies, and tips for	Online	1-hour module - 2weeks for review	10 weeks	Survey using Cultural Competence Assessment (CCA tool)

	Nurse practitioner-run clinics				practice based on identified needs.				Qualitative analysis of open-ended questions
Delgado et al. (2013)	111 Nursing department staff n=98 nurses Department of Nursing at a large medical centre	Evidence-based educational techniques form literature review	Researchers	Different teams of 2 instructors	Class sessions using power points, simulations, lectures, discussions and short web-based learning tasks.	Face to face	1 hour	6 months	Campinha-Bacote's Inventory for Assessing the process of Cultural Competence Among Healthcare Professionals–Revised (IAPCC-R) Survey tool
Kaihlanen et al. (2019)	Registered nurses (n = 14) & practical nurses (n = 6) semi structured interviews n=10 Primary care hospital	Constructivism learning theory	Researchers	An experienced teacher from a multicultural centre	face-to-face sessions with a storytelling-type of lecturing and discussions	Face to face	4 hrs x 4weeks = 16hrs of training	4weeks	Semi – structured interviews
Khanna et al. (2009)	n= 43 (Health care staff including nurses two large regional Medical groups	Institute of Medicine (IOM)-and Culturally and Linguistically Appropriate Services in Health Care (CLAS)-based cultural competency training program	Researchers	Researchers	Workshop	Face to face	4hrs of training offered in 4 continuing education units	12 months	Post then pre-method of survey using Cultural Competence Assessment (CCA) tool

Lange *et al.* (2013)	74 health care staff (n=30 nurses) Residential and home care agencies	ASKED model guided by Camphina Bacote's cultural competency model	2x baccalaureate nurses prepared the sessions. An outside expert in cultural competency training provided feedback on learning material	On site session by 2x baccalaureate nurses pursuing graduate nursing degrees.	group interactive sessions	Face to face	10-12 x 1 hourly sessions over 1yr Session was conducted at the 5th of the ELDER project	6yrs	Cultural Self-Efficacy Scale (CSES) open-ended structured exit interviews and participant journals
Lin & Hsu (2020)	n= 100 nurses experimental group (n = 47) & control group (n = 50) Medical centre	Referred Cultural competence course developed by Campinha-Bacote (2002) for content and structural design.	Three related education experts provided feedback and modified the course according to participant feedback.	two lecturers currently working toward a Ph.D. in nursing who were trained in cultivating multicultural competence.	Storytelling, role play, self- reflection	Face to face	4 units x 3hrs (each session) =12 hrs 4-week follow up after intervention	11months	The Nursing Cultural Competence Scale (NCCS)
McDonough et al. (2013)	57 mental health professionals n=18 psychiatric nurses Goulburn Valley Area Mental Health Service (GVAMHS)	Trans cultural Secondary consultation model	Victorian Transcultural Mental Health (VTMH) and Goulburn Valley Area Mental Health Service (GVAMHS)	Members of GVAMHS's cultural working group, including cultural portfolio holders (CPHs),	Clinical Case presentations, Discussions	Face to face and video conferencing	A series of eight consultations- 5 were face-to-face and 3 were carried out via videoconference	9 months	Case reports, Semi - structured interviews, self-rated learning outcomes
McDougle et al. (2010)	601 health workers n= 72 nurses Ohio state-wide	CARE (Consider, Accept, Recognize, and Execute) model	Different health organisations and consultants	experienced and qualified health care/human service trainers/facilitators	Interactive course format	Face to face	3hr training	25 months	CARE Training Program Survey Questionnaire
Owiti et al. (2014)	94 mental health clinicians n= 17 community psychiatric nurses	Cultural consultation service (CCS) model	Cultural consultants and Care coordinators	Mental health clinicians from diverse ethnicities and different professional backgrounds	Case presentations	Face to face	84 cultural consultation	17 months	Barts Explanatory Model Inventory (BEMI) for ethnographic and narrative-based assessment, modified version of the Tool for Assessing Cultural

	4 NHS community mental health teams								Competence Training (TACCT) for quantitative evaluation of cultural competence of clinicians
Palmer et.al (2011)	103 community health centre staff n=43 nurses n=19 NPs Community based health centres	National Standards on Culturally and Linguistically Appropriate Services (CLAS) in U.S Health Care and using LEARN (Listen, Explain, Acknowledge, Recommend, Negotiate) model	The content drafted by study team and a multimedia company developed the user interface, graphics, and video.	Interactive web-based CME course	Continuing medical education (CME) curriculum using graphics and narration	Online	1 hr	Unclear	Survey using a single group Pre -test post- test design
Santhana m-Martin et al. (2017)	82 participants n=29 psychiatric nurses, n=2 Reg Nurses State-wide public mental health services in rural and metropolitan Victoria	Transcultural secondary consultation model - framework of recovery principles integrated with clinical care from cultural perspectives.	Transcultural Secondary consultation sessions	cultural portfolio holders (CPH) and VTMH lead facilitator	Case conference	Face to face	12 consultations x 90mins	12 months	Case reports Interviews
Wilson et al. (2010)	n=28 health science faculty (78% were nursing faculty) School of Health Sciences	The culturally competent model of care by Campinha-Bacote	Not reported	Not reported	Cultural competence workshop	Not reported	Not reported	12 months	Survey using Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals (IAPCC)

Table 4: Cultural competence training approaches

Publication	Content of Training curriculum
Cross-cultural approaches	
Bennett, J. (2013)	The study's essential topics included culture and the impact of assumptions, Decision-making, communications, and power, valuing cultural differences, promoting race equality, empowering and understanding discriminatory situations, and a Holistic approach to needs identification and risk work. The learning outcomes were set for different days were: Describe a useful model of culture and gain an appreciation of the complexity of culture, identify personal, team and organisational styles of decision making, describe the impact of culture on experience, expression of and responses to mental distress.
Berlin *et al.* (2010)	In the Race Equality and Cultural Capability (RECC) training, the theory part of the training includes cultural awareness, cultural knowledge, cultural skills. The learning outcomes were awareness concerning the importance of cultural awareness concerning clients and the importance of training for nurses; awareness and understanding of the nurses' own culture and professional background, bias, and prejudices; knowledge concerning migration, ethnicity, and cultural influence on health, national and local policy concerning cultural diversity; skills in dealing with socio-cultural issues concerning assessment, cross-cultural communication, eliciting different perspectives, negotiating, and providing health services. The training's clinical / practice component included cultural skills and cultural encounters, which encompassed clinical work in the health services during the four weeks to apply what was learned in the theoretical session and use of theoretical models when reflecting and solving clinical areas. The learning outcomes were skills in dealing with the socio-cultural issues in health services, confidence when dealing with cross-cultural encounters or situations
Bhat et al. (2015)	The training modules focused on self-assessment and culture-specific definitions, increasing RN's knowledge of the hospital's patient population's cultural traditions and describing how to perform cultural assessments and develop culturally congruent care plans using Leininger's cultural care decision and action modes.
Debiasi & Selleck (2017)	The cultural competency training module with the Purnell Model as the framework was focused on increasing nurse practitioners' self-awareness by assessing their baseline level of cultural competence, personal characteristics of diversity, and personal world view related to health and wellness, and illness. It is also served to educate NPs on how to provide culturally competent care to all clients through appropriate questions and client teaching and documentation of cultural assessments.
Delgado et al. (2013)	The cultural competence training consisted of a class session titled "What's Culture Got to Do with It?" intending to promote the understanding of cultural competence and demonstrate the impact on the quality of care. Participants also explored their cultural heritage, health disparity issues, and implications for health care providers.
Kaihlanen *et al.* (2019)	Cultural awareness was chosen as the primary construct for the training because self-reflection on one's own culture can be seen as an essential component of cultural competence. Understanding one's cultural features and values help understand others' beliefs, values, and behaviour. The training consisted of sessions on culture and cultural dimensions and how these occur in everyday life; sessions on significance of being aware of own cultural featured to understand others, how are own cultural features constructed and visualised in health care work, applicability of cultural' facts' or assumptions in-patient care, cultural pain- background and previous experience influencing pain perception, cultural cage- regulating behaviour towards others; communication session included personal space, and how it is communicated, own cultural features and challenges, cultural values affecting communication, importance of sound and understandable communication with patients from different cultural background, issues during communication process; another session on meaning of conviction included – attitudes towards spiritualism, meaning of attitudes in health care context, interaction between culture and religion and its intricacies, how to value a patient's convictions and spirituality and an introduction to a conversational model (opening model) to assess patients' spiritual needs.

Khanna *et al.* (2009)	The training program covered broad cultural competency topics such as: defining cultural and linguistic competency, understanding ethnic and racial health disparities, exploring the relationship between culture and health beliefs, and the significance of cultural competency in effective patient-provider communication. Following the completion of the training, the participants were able to: define culture and describe the spectrum of diversity, differentiating between culture, race, and ethnicity; recognise and describe intercultural and intracultural diversity; understand the difference between cultural generalisations and stereotypes; define cultural competency and examine its individual and institutional foundations, explain the concept of cultural competency continuum and reflect upon their position on the cultural competency continuum; describe the use of using explanatory models and their importance in patient-practitioner interaction.
Lange *et al.* (2013)	The training consisted of five steps: developing awareness of differences, acquiring skills to assess those differences, seeking knowledge of other cultures, engaging with different individuals, and having the desire to changes one beliefs and attitudes about others. Sessions were intended to enhance participants' insight into their attitudes, upskill cultural assessment and communication ability, improve knowledge, and gain insight into other cultures through discussions, activities, and engagement with diverse group members.
Lin & Hsu (2020)	Unit 1 in training modules explained the education intervention program's procedures, information on cultural competence for nurses and issues related to cultural diversity; Unit 2 had storytelling by experts experienced in interacting with immigrant families to increase participant's empathy toward new immigrant; Unit 3 involved by watching a movie on the racial war between two countries to inspire participants reflection on different cultures. This unit prompted participants to understand the process of prejudice and stereotype regarding cultures through self-reflection, critiquing, and innovation and thereby establishing a positive attitude towards various cultures; the unit4 in the module, a structured role-play was used to trigger participants reflection on how prejudices and privileges influence people's lives. This unit also enabled the participant to comprehend the importance of respecting cultural diversity, thereby establishing an empathetic and trustful relationship with people of different ethnicities.
McDonough et al. (2013)	A series of eight secondary pilot consultations were facilitated by the VTMH and attended by clinicians; five sessions were directed face-to-face and three by videoconference. Facilitators recorded the details of discussions at each session. Participants and facilitators offered feedback analyzed to improve the quality of cultural responsiveness at the mental health service. The Pilot Transcultural Secondary Consultation Program consolidated learning from a cultural competence training program and provided the clinicians with an opportunity to demonstrate and extend their knowledge and skills, a forum in which to reflect on cross-cultural mental health issues and for discussing how to practice organisational and community-based factors influence the way particular individuals' access and utilise services
McDougle et al. (2010)	The CARE (Cultural Awareness and Respect Through Education) Columbus cultural competency training program had the introductory curriculum entitled "Building Cross-Cultural Competence in Health care," had an overview of the curriculum development process; completion of CARE exercises to affect attitudes, knowledge, and skills: "Consider—exercise" instructs trainees about assumptions and intercultural issues that block communication, "Accept—exercise" instructs trainees about aspects of culture that influence the health care setting, "Recognize—exercise" instructs trainees about behaviours of a culturally competent health care provider, "Execute—exercise" instructs trainees to conduct culturally sensitive medical interviews and how to give instructions in a culturally sensitive manner.
Owiti et al. (2014)	The Cultural competence training through Cultural Consultation Service (CCS)model facilitated an 'in vivo' learning assisted in cultural competence skills through a dynamic interactive learning process within real clinical encounters. This model is an innovative way of facilitating in-service workforce development in transferrable cultural competence skills in secondary care settings; through real clinical cases and ongoing care challenges and complexities in clinical practice, clinicians compared the CCS model of learning with the existing one-off didactic training. Clinicians could immediately link cultural competence with improved engagement, patient satisfaction, and better outcomes.
Palmer et.al (2011)	This training utilized breast cancer screening as an ideal health topic to teach the importance of cultural competence is given the different beliefs and attitudes toward breast screening across cultural groups. The training modules provided the learner with an outline of breast cancer etiology and epidemiology,

	procedures for mammography screening and clinical breast exam, an overview of what culture is, and how culture can influence women's breast cancer screening decisions. The final module LEARN communication model (Listen, Explain, Acknowledge, Recommend, Negotiate), helped healthcare workers overcome communication and cultural barriers to successful patient education.
Santhanam-Martin et al. (2017)	The transcultural secondary consultation model facilitated a multidisciplinary collaboration and a facilitated space for clinical teams to explore culturally responsive therapeutic practices. The consultation process raised awareness and built the skills and knowledge of practitioners in clinical mental health. It provided a platform to discuss the usefulness of cultural issues in assessment and the application of explanatory models as a therapeutic tool. It also provided a reflective space for practitioners to explore clinical assessment and therapeutic dilemmas in providing integrated care.
Wilson et al. (2010)	The cultural competence workshop provided faculty skills to integrate cultural competency within the curriculum better and when interacting with students.