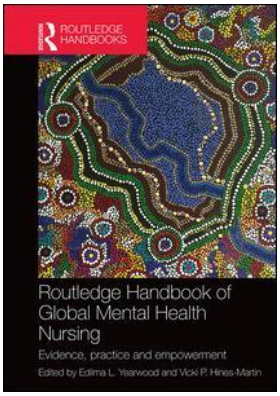

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THE EFFECTS OF CULTURE AND STIGMA ON MENTAL HEALTH

Deena A. Nardi, Roberta Waite and Edilma L. Yearwood

Introduction

This chapter uses an ecological model of the social determinants of health to present the implications of culture and stigma on the mental health of populations and associated recommended treatments. This model illustrates the interrelationships of diverse determinants of health and well-being and their impact on individuals, populations, and societies (Guy, 2007). Stigma and its role in preventing timely, effective treatment of mental health disorders are examined. In addition, resources are identified that can inform and support the cultural competencies of nurse providers of psychiatric mental health care in regional, national, and global arenas.

Optimizing global mental health outcomes requires a concerted commitment by many individuals worldwide to modify the core contributing factors of mental health challenges and disparities, including internal and external influences such as personal and societal stigma as well as cultural considerations. These cultural considerations influence decision-making at all levels of health care, from individual patient and consumer care to policy-making. Globally, addressing mental health concerns in a timely and effective manner requires greater emphasis due to the wide range of implications of untreated health concerns for individuals, families, communities, and ultimately, the world. Beyond individual facilitators and barriers to seeking mental health services, there is an associated unfair, unequitable, and unethical distribution of resource dissemination such as information and treatment provisions (Ngui, Khasakhala, Ndetei, & Roberts, 2010). Also lacking are mental health and primary care policies that are comprehensive and protective, from a legal and human rights perspective for individuals affected by mental disorders, including their families (Ngui *et al.*, 2010).

Stigma

Stigma, defined as myths and fallacies in thought and actions regarding mental illness, contributes to a significant level of discrimination and human rights abuses endured by individuals with mental conditions (Ngui *et al.*, 2011). In developing countries the encumbrance of mental disorders is magnified by extraordinary rates of stigma and discrimination as evidenced by the poor treatment those with mental ill health receive. Notably, these factors are major impediments

in the delivery and utilization of mental health services regardless of a person's age (Kleintjes, Lund & Flisher, 2010). Stigma therefore affects: (1) an individual's willingness to disclose and seek help; (2) the quality of health care received; and (3) access to mental health services to support recovery (Kleintjes *et al.*, 2010). Moreover, there can be secondary stigma extended to the family as a result of association with individuals affected by mental illness. This can contribute to the family members mistreating, alienating, and/or rejecting the individual(s) affected by mental illness (Kleintjes *et al.*, 2010).

Stigma involves discrediting an individual or group, which results in labeling as "out" or apart from others. The stigma label affixed is negative and serves to separate or highlight a difference between the stigmatized individual or group and others, and this label results in discrimination, loss of status, low self-esteem, and limited or no access to social opportunities (Corrigan, 2004; Link & Phelan, 2006). An underlying and influential element of stigma is a power imbalance, with power exerted over the stigmatized individual (Bos, Pryor, Reeder, & Stutterheim, 2013). Stigma alleviation is particularly challenged by its existence at multiple levels, public, individual and structural, requiring a multi-layered approach to support a positive outcome (Corrigan, Druss, & Perlick, 2014).

Stigma and discrimination, against individuals with mental health challenges, leads to human rights violations in civil, cultural, economic, political, or social spheres (Drew *et al.*, 2011). Human rights are rights that no one should be able to exclude. Fundamentally, each individual should have the freedom to partake in community life while being able to live independently. Human rights therefore endorses that persons with mental illness have complete respect, dignity, and recognition as being human (Drew *et al.*, 2011). However, when stigmatizing views infiltrate the minds of policy makers and funders, development and investment in mental health can be stymied and this ultimately contributes to the low priority of global mental health in the world's public agenda (Kleintjes *et al.*, 2010). However, there are examples of positive policy decisions to improve mental health. Nepal has been improving awareness of mental health and related problems through its national mental health policy. Nepal has specifically addressed the following: providing care in the community, educating the public, connecting with communities, and monitoring community mental health through the introduction of mental health first aid (Jha, Kitchener, Pradhan, Shyangwa, & Nakarm, 2012).

Culture

Cultural values, beliefs and processes can significantly impact mental health. Myers (2010, p. 505) reports that culture is often perceived as "symbolic apparatuses of meaning making, representation, and transmission." This outlook is closely linked with political and economic practices within society and are recognized and lived in local domains and beyond. Culture is conveyed to individuals through "experience," or a "felt flow of interpersonal communications and engagements" that "take place in a local world" and are "thoroughly intersubjective" (Myers, 2010, p. 505). Therefore, everything individuals have learned and appreciated about their history reflecting customary behaviors and actions as well as personal beliefs is indicative of an individual's culture (Bryan & Morrow, 2011).

Arnault (2009) describes culture as being a set of interrelating, system-level, social practices that encompass four interconnected dimensions—cultural ideology, political/economic dimension, practice, and the body. *Cultural ideology* are beliefs and values held by individuals relating to what is good, right and normal; it denotes symbols, meanings, and values regarding what is significant and what behaviors are appropriate and accurate. *Political/economic* characteristics

of culture comprise the social structures of the society including how families and organizations allocate resources, assign labor, and obtain and distribute capital/wealth. This dimension accounts for how individuals in a position of power and influence define proper social behavior and how public conduct will be controlled. Cultural ideology informs the political/economic dimension of culture since cultural beliefs and values define what is considered "good" and "right," and rationalizes to explain why certain individuals are able to hold positions of power and over whom. The culture of *practice*, embodiment of tradition, encompasses traditional behaviors, spatial organization, and relational behaviors. Two central features under the practice domain include power and ideals in gestures, language patterns, custom of dress, social space allotted, food selections, and health behaviors. Arnault (2009) relates that cultural practices are representations of both cultural ideology and political/economy at the personal or group level. Lastly, the *body* is perceived as cultural in three significant ways— individuals experience the body as the "individual body-self" based on cultural prescriptions and templates; each person experiences themselves as having as a social body, which is a natural symbol for culturally based thinking about relationships among nature, society and culture; and finally, the body is political, in that it is an artifact of, and is subject to, culturally based social and political control (Arnault, 2009, p. 261).

The overlapping cultural dimensions of *ideology*, *political/economic, and practice* exert their effects on the body, specifically how these dimensions are lived through the body (Arnault, 2009). Importantly, these cultural forces occur in, and are shaped by, the geographic setting in which individuals live.

Given that culture encompasses the totality of principles, beliefs, abilities, customs, and institutions into which each member of society is born, being able to appreciate and understand the cultural context of individuals who receive mental health services is an essential professional competency. Culturally relevant proficiency and skills are necessary for ethical practice. An understanding of the impact of social context and worldviews on behavior is vital to the course of mental health service provision (Bryan & Morrow, 2011).

Description and discussion of the issues

Promoting global mental health enables the enhancement of healthy development across the life span including supporting individuals to realize educational, social, and economic goals. Moreover, optimizing mental health contributes to prevention of both communicable and noncommunicable health difficulties and early mortality (Jenkins, Baingana, Ahmad, McDaid, & Atun, 2011). Currently, however, the status of global mental health demonstrates a failure of humanity (Kleinman, 2009). The reality is that most individuals around the world, particularly those affected by mental illness living in developing countries, endure dreadful conditions beyond negative words that are stigmatizing. Kleinman (2009), a global mental health expert, has witnessed individuals with mental disorders in abysmal situations including being chained to beds; imprisoned in small cells constructed behind houses; isolated in concrete rooms with a hole in the floor for urine and feces in for-profit asylums; maltreated by traditional healers to the point of being starved and infected with tuberculosis; disfigured through burns as a consequence of inappropriate safeguarding from cooking fires; compelled to endure electroconvulsive therapy when psychotic; apprehended by the police; concealed by families; stoned by local youth; and treated in a manner devoid of dignity, respect, or protection by health care personnel. These behaviors and manners of treatment are readily apparent in small towns and villages as experienced by Kleinman (2009) and constitute some of the most inhumane treatment by man of his fellow human being.

Fundamentally, global mental health is a moral and human rights issue. Pertinent factors associated with principles underlying global mental health include: *mental capital, social capital*, and *political capital*. *Mental capital* is the cognitive and emotional effects that influence how well a person is able to contribute to society and is linked with positive mental health. Jenkins and colleagues (2011) state that positive mental health encompasses critical factors such as an improved sense of well-being; a belief in one's own worth and dignity including valuing others; personal assets such as self-esteem, hopefulness and sense of mastery and rationality; the capacity to initiate, cultivate, and endure mutually satisfying relations; and the ability to manage adversity. Collectively, these factors contribute to an individual's capability to enhance family dynamics, other social networks including the local community, and society in general (Jenkins *et al.*, 2011). Hence, mental health extends beyond the absence of symptoms or distress. Mental capital is also influenced by both mental health and physical health; they are interrelated, each influencing outcomes as indispensable aspects of an individual's general health. Importantly, they are an inseparable measure of public health. This endorses the modern-day phrase "there is no health without mental health" (Patel, 2012, p. 7). Thus, mental capital covers our conceptual understanding of "the bank account of the mind," encompassing "intellectual and emotional resources which can be built up or depleted or damaged through life" (Jenkins *et al.*, 2011, p. 70). Collective mental capital is undoubtedly significant for nations in quest of prosperous development.

Social capital is the helpfulness created by social networks including social relations and relates to the efficacy of participation in social reciprocity such as fundamental cultural practices of living a conventional lifestyle. This includes participation in marriage, work-related activities, academic functions, celebrations, commemorations, mourning rituals, and in commonplace experience in marketplaces, stores, and in other related ordinary activities (Jenkins *et al.*, 2011). Modern-day issues that affect social capital in many countries, and ultimately impacts mental health, include the impending rise of population growth and aging; marital and household breakdown; a growing number of orphans contributing to the growth in child-headed family units; and immigration both from rural to urban regions within a country as well as across international boundaries (Jenkins *et al.*, 2011). Additional issues that warrant attention and that influence social capital include fluctuating patterns of work availability, climate change, the threat of debt and amplified disparity in earnings, and increased alcohol and substance abuse. Issues that contribute to poor mental health will have an undesirable effect on physical health, and on expansive social and economic areas (Jenkins *et al.*, 2011).

Political capital includes access to political events and decision-making and is needed in order to tackle pervasive global mental health issues. Even with the high disease burden, global mental illness has not attained proportionate visibility, policy attention, or financial support (Tomlinson & Lund, 2012). Overarching steps that can support deserved attention in addressing our global mental health calamity include two central areas. First, political and international leaders must publicly and privately champion for improvement in global mental health in an unrelenting manner (Tomlinson & Lund, 2012). To date, there has been a low political will of countries to act on the evidence of global mental health disorders. Countries such as Brazil and India have exhibited some aptitude to establish their own health agendas independent of foreign contributors. These countries are also now allocating larger resources to mental health; however, these provisions continue to be inadequate based on the scale of unmet needs. In countries whose health policies are influenced by international donors, the potential to prioritize mental health can be obstructed by views that mental health is not urgent for individuals who are poor and reside in less-resourced countries (Patel, 2012). For example, 44 percent of African countries do not have a mental health policy and 33 percent do not have a mental health plan (Tomlinson

& Lund, 2012). Low- and middle-income countries struggle significantly with getting resources appropriate to the disease burden. As a global median 2.8 percent of health budgets are apportioned to mental health; however, broad variations exist with the mental health portion ranging from 0.53 percent for low-income countries to 5.10 percent for high-income countries. Second, and most importantly, not addressing global mental health is a social justice issue. Social justice advocates for "a societal state in which all members of a society have the same basic rights, security, opportunities, obligations, and social benefits" (Pope & Turner, 2009, p. 194).

Mental health treatment of populations

The increasing globalization of the world presents critical challenges as well as opportunities for psychiatric and mental health providers to effect positive change in perspectives and treatment. Globalization has brought disparate communities closer than ever before. The technologically enhanced instant interactions of different cultures provide access to new knowledge and more resources, yet it also creates new vulnerabilities to acts of terror, all forms of abuse, and the loss of cultural or political identity. Communities around the globe are confronting major issues that directly affect psychiatric/mental health and health care, including nurse and health provider migration; childhood poverty; malnourishment and ill health; rapid scientific and technological advances; political and financial destabilization; access to arms, explosives and guns; aging populations; and family, community, and political violence. These issues are experienced through the lenses of cultural-based attitudes, values and beliefs that influence the responses of individuals and communities to these stressors. Understanding the cultural influences on our patients' behaviors as well as our own improves nurses' ability to best respond to the needs of our patients, and to help them reach their personal health goals. This is a lifelong task, since the cultures in which we grow, work and live, are constantly interacting with other cultures, and changing in subtle, and not so subtle, ways. This purports that nurses must support and enhance their cultural competency through lifelong learning, continued self-awareness, and keeping a primary focus on the individual and individual's concerns when providing all level of care.

The relationship of culture to global mental health nursing

Nurses who are attentive to the cultural determinants of mental health will incorporate patient-centered information to actively shape and support their interpersonal communications, assessments, diagnosing, treatment planning, and follow-up. Nursing actions used to support treatment should be current, culturally adaptable to the populations served, relevant to the nurse's role in the system of care, and evidence based. Using an ecological perspective, these resources are used when negotiating the interrelated micro, exo and macro systems (Bronfenbrenner, 1979, 1994, 2005).

Microsystem resources that affect roles and experiences are used when working with the patients' symptoms, beliefs, perceptions, age, and health. Some microsystem resources are the nurse's own education and experience with each population, and the published assessment and intervention guidelines the nurse uses when working individually with the patient. Nurses must understand the laws and policies of the exosystem that the patient lives and works in in order to best support patients' return to their optimum level of health, return to work, and return to a degree of wellness in that society. Exosystem resources, connections and relationships, are used when communicating with social services, the work environment, or political bureaucracies. Nurses use the macrosystem resources (beliefs and customs) to clarify the attitudes, economics

and ideologies of the patient's culture, and improve their general cultural understanding and competency. Their informed understandings of the influences of these interconnected systems serve to guide nurses' psychiatric evaluations and cultural assessments.

Culturally competent assessment

In order to optimize care, the nurse or health care provider should start with a basic assessment that includes a personal review of cultural factors that may influence care. If psychiatric services providers believe that understanding the patient's cultural context is essential for comprehensive and effective assessment, diagnosis, and treatment, then it follows that the initial psychiatric interview must include a cultural assessment from the individual's personal and lived experiences. This cultural assessment, also called "cultural formulation interview" or CFI, by the Multicultural Resource Centre (2014), as well as the American Psychiatric Association (2013b, p. 750), has become a key component of any psychiatric diagnostic evaluation. Table 5.1 illustrates questions that can be included while conducting a cultural assessment.

The CFI consists of categories of questions that enable the interviewer to examine the patient's culturally influenced definitions of the problem, its causes, the patient's social, economic and metaphysical supports including spirituality, coping behaviors, and help-seeking behaviors. Each section includes sample questions, with rationale and purpose, and a guide to approaching the patient that interviewers can use to elicit answers. The APA also offers supplementary modules to the CFI that providers may use in research, and for detailed cultural assessment with follow-up questions (American Psychiatric Association, 2013b). These modules, as well as the CFI, can be used initially for assessment, and throughout the care of the patient, as individual social networks, finances, and the supportive environment often change with time and circumstance. And since these changes affect health outcomes, they should be identified and incorporated into the plan of care in an iterative manner.

The CFI should be conducted during an initial assessment. Demographic data from the electronic health record, gathered prior to this interview, can then be used to tailor the interview questions to the patient's current situation. There are many versions of the CFI to guide the cultural assessment, and it is published in some form in many languages. The original CFI guide is published in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5), and can be located in its Section III: Emerging Measures and Models (see American Psychiatric Association, 2013a, pp. 749–759). The DSM-5 is also cross-referenced to the International Classification of Diseases (ICD-9 and 10), and planned to be congruent with ICD-11 for global use by countries that are signatory to WHO and the UN (American Psychiatric Association, 2013a, pp. 10–11).

Resources for practice

Globally, there are approximately 150 national nurses associations (NNA) that are members of the International Council of Nurses (ICN), (International Council of Nurses, 2013). Each NNA provides information, guidelines and data to support and enhance the cultural competency of their country's nurses. Additionally, the country's national standards of psychiatric mental health practice, if they exist, also guide practice. It is well understood that countries with limited resources, must also develop practice standards. However, in the absence of standards, practice can be informed by using exemplars from around the world. For instance, the Canadian Nurses Association provides a link on their website to a nursing education framework for nurses caring for individuals of First Nations, Inuit and Métis populations. The purpose of the framework is to prepare nurses to work with indigenous peoples in Canada, through the fostering of

Table 5.1 The DSM-5 cultural formulation outline

Cultural classifications	*Examples of question format*	*Intent to determine:*
Culturally based values, beliefs, and practices (cultural identity)	1 Could you tell us about how this problem has affected you and your family? 2 Do you have an idea about what caused this problem? 3 Which part of this problem is most troubling?	1 Patient understanding of the problem 2 How the patient frames the problem 3 Prioritization and ranking of aspects of the problem
Cultural conceptualization of distress and supports	4 Why do you think you have this problem? 5 What does your family say contributes to this problem? 6 What or who helps you to cope with this problem? 7 Is there anything in the environment that contributes to this problem? 8 What is most important to you about your culture? 9 What aspects of your cultural background help you cope? 10 What aspects of our culture make the problem worse?	4 Meaning given to the problem 5 Perspectives of others close to patient 6 Social supports and supportive networks 7 Enviromenmntal stressors 8 Aspects of cultural identity 9 Role of cultural identity in causing or alleviating distress 10 A probe to explore cultural identity
Psychosocial stressors, vulnerability and resilience	11 How do you cope with the problem? Can you give me an example? 12 People look for help from all sorts of sources. What resources or providers have you used to help with this problem? 13 What prevents you from getting help for this problem?	11 Relevant self-coping behaviors 12 Exploring actual and potential sources of support 13 Social barriers to help seeking behaviors
Cultural features of relationships	14 What kinds of help would be useful to you now to deal with this problem? 15 What kinds of help have been suggested to you? 16 Do you have any concerns about receiving help from this program that we can talk about now?	14 Perspective on what type of help/support is needed 15 Perspective on helpfulness of social network support 16 Perspectives on receiving meaningful help
Overall cultural assessment	Summarizes results of the CFI and how it can best be used to appropriately diagnose, treat, and manage the disorder with the patient	

Source: Adapted from the cultural formulation interview (American Psychiatric Association, 2013a). See the interview, pages 749–759, for specific questions and interview format.

"awareness, sensitivity, competence, and moreover the need for *cultural safety* in the care of clients, including First Nation, Inuit, and Métis peoples" (Hart-Waskeesikaw, 2009, p. 1).

The World Health Organization (WHO) proposed a comprehensive mental health action plan in 2012, and it was formally approved at the sixty-sixth World Health Assembly (World Health Organization, 2013). The action plan used two objectives whose outcomes would be directly related to the cultural competencies of mental health providers and all who practice in this field: " . . . (2) to provide comprehensive, integrated and responsive mental health and social care services in community-based settings; (3) to implement strategies for promotion and prevention in mental health" (World Health Organization, 2013, p. 6). Providing health and social services that promote and prevent mental health disorders requires responsiveness founded on commitment to, education about, and respect for, all populations served. These attributes are the hallmarks of culturally competent nursing care. The action plan began in 2013; its goals are scheduled to be accomplished by 2020. The plan can be accessed at http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R8-en.pdf and includes actions and strategies that nursing leadership can use to promote mental health patient empowerment, as well as to improve provider responsiveness to vulnerable or marginalized populations who are at increased risk for poorer mental health outcomes.

Another example of the role of NNAs in supporting the cultural competencies of their country's nurses is the Trained Nurses Association of India, which provides links to its new initiatives to promote health care to rural populations. Its position statements on human rights and culturally appropriate health care, advocates for equitable access and treatment for women (Trained Nurses Association, 2013). In the US, a toolkit for teaching and enhancing cultural competency in master's and doctoral education that the American Association of Colleges of Nursing hosts on its webpage, and which can be accessed at www.aacn.nche.edu/education-resources/Cultural_Competency_Toolkit_Grad.pdf (AACN, 2011), provides references for health literacy and cross-cultural communication, and resources for faculty, students and practicing nurses.

There are many international organizations that provide strategies for culturally competent care to the global mental health provider community. These resources can be adapted to multicultural as well as distinct populations, and are useful to the lifelong learning of a diverse workforce, especially considering the immigration, migration, and rapid cultural changes produced by technology, which are experienced by all populations. Table 5.2 lists examples of the resources of the global community that are specific to psychiatric mental health care, the organization that sponsors each of the resources, and suggested uses.

Global standards for culturally competent mental health nursing practice

As the world shifts to an increasingly global perceptive on health care, there is a critical need for mental health nurses who can comfortably and competently work with diverse populations. The interactive influence of a number of factors such as the creation of the European Union, the global economy, the global migration of nurses and other health care providers, and the universal use of technology, especially web-based learning and entertainment, accelerates the interconnectedness of cultures. Another example of global interconnectedness is the increase in cross-border care. This term "cross-border care" refers to "medical services involving the movement of information, patients, and health care providers across national borders. These three elements—information, patients, and health care providers—are intertwined" (Nakajima, 2012, p. 6.) This practice is vibrant and growing. For instance, in the European Union, patients already have identified rights to cross-border health care (*Directive on Cross-Border Healthcare*,

Table 5.2 Global resources to support culturally competent mental health nursing practice

Organization	*Host country and mission*	*Examples of resources*
International Council of Nursing (ICN)	**Geneva, Switzerland** Ensures universal access to quality nursing care for all, sound global health policies, advancement of nursing knowledge	Nurses and Human Rights Position Paper (ICN, 2011). Global networking
International Society of Psychiatric-Mental Health Nurses (ISPN)	**Wisconsin, USA** To unify and strengthen the voice of psychiatric/mental health nurses	Advocacy Culturally competent curriculum guidelines Global networking
The Mental Health Consultation and Liaison Nurses Association of New South Wales and Australia Capital Territory	**Blacktown, NSW, Australia** Group of mental health nurses who provide liaison and consultation to medical and health care providers and settings. Membership services include networking and support	e-learning modules for Global Culturally and Linguistically Appropriate Services (CLAS) Standards in health and health care
Movement for Global Mental Health	**Melbourne, Australia** An evidence-based repository of articles, narratives, databases and other documents re human rights	Articles focused on the human rights of and advocacy for the mentally ill Databases
Multicultural Mental Health Resource Centre	**Calgary, Alberta, Canada** To improve access to quality mental health services for diverse populations	Cultural competence training, workshops and guidelines Mental health listserv CFI
Pacific Islands Mental Health Network (PIMHnet)	**Wellington, New Zealand** For the Western Pacific region of WHO nations. A network of Pacific Island countries to advocate, collaborate, and combine resources for effective mental health promotion and treatment	Publications Advocacy mhGAP Intervention Guide (mhGAP-IG)
Royal College of Nursing	**London, England, UK** Professional union; voice for nurses in the UK and abroad	Publications and e-learning to support transcultural nursing
Transcultural Nursing Society (TCS)	**Michigan, USA** Improve culturally congruent and competent health outcomes to improve health outcomes for people worldwide	Cultural competence resources Standards of practice for culturally competent nursing care
US Department of Health and Human Services Department of Minority Health	**US/Washington D.C.** To develop health policies and programs that assist in eliminating health disparities for racial and ethnic minorities.	Resources for CLAS standards in health and health care
World Health Organization (WHO)	**Geneva, Switzerland** The public health arm of the United Nations	Programmes for managing and intervening for mental health disorders
World Psychiatric Association (WPA)	**Chene-Bourg, Geneva, Switzerland** "To promote the advancement of psychiatry and mental health for all peoples of the world" (About the World Psychiatric Association, 2013)	Transcultural conferences and educational programmes Train the trainer workshops Journals

2011). In Canada, government approvals for Canadian nationals to receive health care in the USA have increased 450 percent (Cross-Border Care, 2012). In the USA, Blue Shield and Health Net California provide cross-border insurance policies to both US citizens and Mexican nationals (Schulz & Medlin, 2007), and the interest by other states in cross-border care in the US is growing. This increase in interconnectiveness of cross-border care, and global migration calls for standardization of at least a basic level of cultural competency that nurses can then use with the populations and cultures they serve.

There is a movement toward this basic standardization of culturally competent nursing care. The Horatio-European Psychiatric Nurses was formed in 2005, and in a few years its membership has grown to organizations from over 25 countries. Its purpose is to strengthen the voice and role of psychiatric mental health nursing in all aspects of patient care. Its expert panel of members developed the *Turku Declaration: A Consensus Document on Psychiatric-Mental Health Nursing Roles, Education and Practice* for all European PMHNs (Ward, 2011). This document outlines basic principles for PMH education, practice, and professional development. Although cultural skills are not mentioned specifically in the document, it emphasizes the central role of the PMH nurses in creating and using the therapeutic relationship with the patient, to provide patient-centered care, and to work within the patient's environment. To do this, PMH nurses must also use a cultural framework of understanding, and work within the culture of the patient.

Universally applicable guidelines for culturally competent nursing care practice were developed by a coalition from members of two professional nursing organizations (The Transcultural Nursing Society and the American Academy of Nurses' (AAN) Expert Panel on Global Nursing and Health) over a 6-year period, 2007–2013. Over 50 documents, including the United Nation's *Declaration of Human Rights* (United Nations, 2008), and the International Council of Nurses' (2006) *Code of Ethics*, were used in his effort. Their purpose was to enhance cultural competence in all nurses, as a priority of any nursing or health care. This document was first published in 2008, and comments from the international community of nurses were used to further refine the document. Its final version was published in the *Journal of Transcultural Nursing* in 2011 (Douglas, *et al.*, 2014). The International Council of Nursing (ICN) endorsed these guidelines in November 2013. They are mentioned in this chapter to provide examples for culturally competent nursing approaches to patient care.

Standards specific to global psychiatric mental health nursing have also been suggested, and published in the *Journal of Psychosocial Nursing and Mental Health Service* (Nardi, Waite, & Killian, 2012). The authors emphasized the need to adapt person-centered mental health care to cultural contexts; these contexts include the ecological, environmental, economic, educational, social, political, spiritual, and familial processes that interact to influence one's values, beliefs, and behaviors. Figure 5.1 depicts the complex systems the nurse must understand and negotiate in order to provide mental health care that is culturally safe and recognizes the human rights that the majority of United Nations member nations have recognized.

The triangle represents culturally congruent health care delivery, from its base of delivery, which derives first from the health care provider's individual and family systems background, based upon their values, beliefs, and behaviors, and their recognition of, and respect for these health care values, beliefs, and behaviors in their patient populations. This transformative process continues through to the point of delivery of culturally congruent health care. The layers of the triangle are not hierarchical, but filter through a transactional and dialectical process to the actual point of care represented at the point of the triangle. This point of care might be at the systems level, such as at a program, school, or hospital, or at a direct patient/provider/therapist level of interaction in a home or treatment program, at any number of politically or economically determined points of care delivery in countries and regions across the globe.

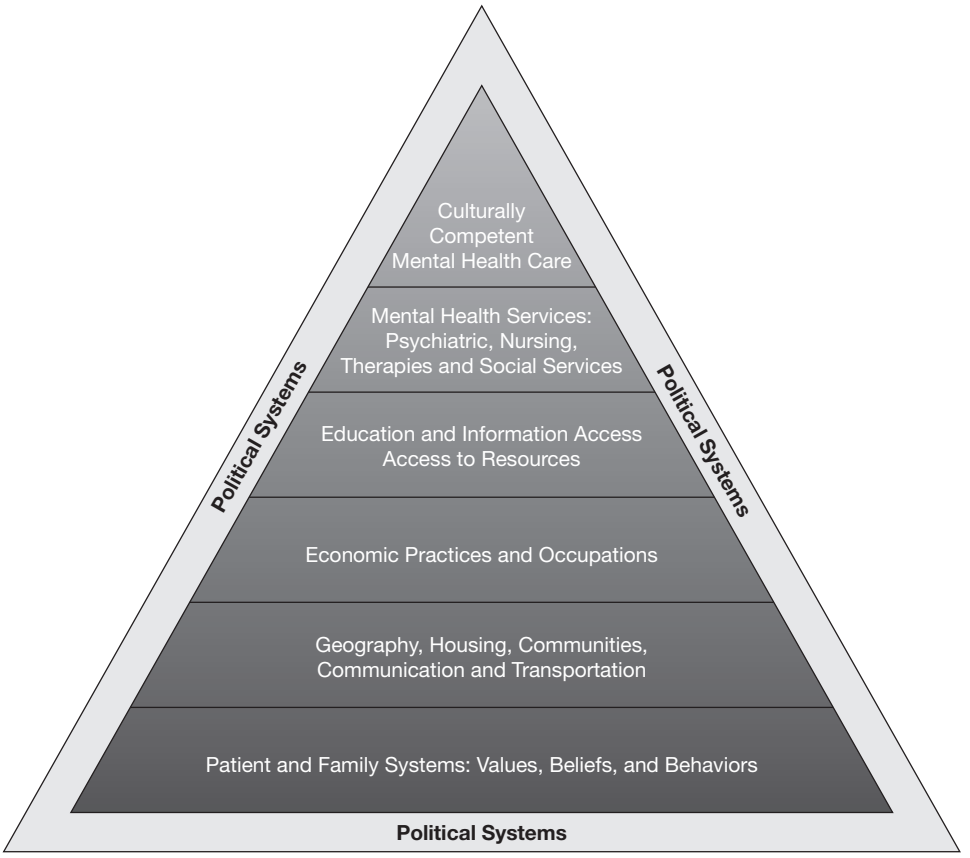

Figure 5.1 Culturally competent mental health care

Culturally competent approaches to mental health care

Providers of mental health care are practicing in a rapidly changing world, and an increasingly diverse society. Accordingly, mental health nurses can apply the guidelines for culturally competent nursing care when creating a therapeutic relationship with their patients, in order to facilitate assessment. This will also strengthen the therapeutic alliance between the patient, patient populations, and the therapist. However, the biggest impediment toward applying these global guidelines and resources to provide culturally competent nursing care is the very inequity in basic levels of nursing education and inconsistency in clinical training.

There is a severe shortage and unfair distribution of global mental health resources and clear obstacles to scaling up services for mental disorders which is informed by two principles—scientific support cost-effective treatments and a regard for the human rights of individuals affected by mental disorders. Transformational changes must occur to attempt to address the treatment gap. Present-day in many communities, mental health care is being delegated to non-specialist health workers who are educated to deliver interventions for particular mental disorders. Task shifting, the strategy of reasonable restructuring tasks among health workforce teams, has developed into an accepted practice for attending to shortages of specialist health resources (Patel, 2012). When

applicable, highly qualified and educated health personnel share specific tasks with health workers having less preparation and fewer qualifications in order to make more effective use of the available human capital (Patel, 2012).

The role of mental health professionals and paraprofessionals

It is incumbent that to effectively address global mental health, the mental health community must have a strong engagement with the agenda at hand in diverse communities and pursue task-sharing strategies to meet the existing needs. Nursing, psychiatry, psychology, couple and family therapists, counselors, and other mental health professions and paraprofessionals, have a vital role to play. With shortages of professional health care providers, available human resources within communities must be "trained up" to provide basic mental health care that includes assessment, support, brief treatment and referral of complex cases to trained providers. Choosing members from the community who are knowledgeable about the fabric and socio-cultural processes in existence are invaluable as trusted cultural brokers, bring credibility to the topic of mental health, and can decrease the associated stigma. A multisite study, the PRogramme for Improving Mental health carE (PRIME) using non-specialist community workers in Uganda, South Africa, Ethiopia, India, Nepal found that the program was both accessible and feasible in providing mental health care within communities by trained lay workers. The success of the program was credited to availability and access to medications, inclusion of structured supervision, adequate initial training, and appropriate financial compensation for the work done (Mendenhall *et al.*, 2014).

Experts need to deliver the supervision required for the successful enactment of task sharing; therefore, traditional work styles like functioning in silos is ill-advised and no longer compatible to meet modern-day needs of our world. Given that front-line mental health care will be shared with nonspecialist health workers, unique demands will be placed on mental health practitioners requiring them to learn and to become proficient in more diverse skill-sets including supervising nonspecialist health workers; be involved in monitoring and assessment for quality assurance of mental health care programs; obtain the management abilities fundamental for directing teams of health workers; and function as advocates for the human rights of individuals with mental disorders (Patel, 2012).

Mental health services

Even with evidence-based knowledge accrued worldwide about mental illness, the everyday experience for most individuals affected by mental disorders has been an indifferent health system that does little to answer to their needs, leading to estimates that up to three out of four affected persons in low- and middle-income countries do not receive the treatments known to help their conditions (Patel, 2012). For example, in sub-Saharan Africa the treatment disparity can surpass 90 percent, for schizophrenia and other psychoses, the most serious and incapacitating of mental disorders. This gap is scarcely unexpected, given that low- and middle-income countries control less than 20 percent of global mental health resources (Patel, 2012). In addition to improving access to evidence-based treatments in low-resource settings, the cultural suitability and appropriateness of treatment is also relevant. This is particularly relevant for psychological treatments since these treatments have been established in high-income countries in distinctly dissimilar cultural contexts. A key example of a treatment viewed as unacceptable in contexts where local communities were unfamiliar with the approach was the use of talk therapy to address mental health problems. Service use by varied cultural groups is also influenced by stigma, competing

work pressures, and low adherence often associated with costs due to time taken to attend sessions and the direct costs of transport to health facilities (Patel, Chowdhary, Rahman, & Verdeli, 2011). Ultimately, to both improve services rendered as well as health outcomes we need to:

- improve our understanding of the root causes of mental disorders;
- develop more effective prevention and early intervention strategies for global mental health that are grounded in evidence, are scalable, and can be shown to have an impact at the structural level;
- conduct research that incorporates a life-course approach recognizing the developmental origins of mental disorders;
- invest in research regarding the nature and treatment of mental disorders that is conducted in both high-income countries and in low- and middle-income countries;
- direct population-based studies that will help us to describe the phenotypes of mental disorders, as well as differences in the distribution of disorders between and within varied populations;
- intentionally engage in anti-stigma campaigns consistently and at multiple levels;
- acknowledge that mental health and environmental exposures, such as extreme poverty and war, are closely related to mental illness; and
- use a research framework that operationalizes principles of social justice and human rights.

(Tomlinson & Lund, 2012)

In summation, we must engage a diverse array of participants including mental health professionals and paraprofessionals, political advocates, global health activists, lay community workers, and individuals and families affected by mental disorders. This form of collective advocacy is needed when fighting for a common goal in order to guarantee that it stays in the foreground of global health efforts (Patel, 2012). Moreover, increasing community solidity and international governance structures need development to add to a more amalgamated voice concerning global mental health, reflecting the social determinants of health. A framework focused on integrated innovation is desirable so that global mental health communicates in a common language that is relevant to national and international policy-makers (Patel, 2012).

Recommendations

Mental health care that is culturally sensitive and respectful of the values, beliefs, and lifeways of patients requires providers who can serve as cultural brokers and change agents to reduce stigma related to psychiatric mental health disorders. Cultural brokers work within the culture of their patient populations to: (1) identify existing stigma related to psychiatric mental health disorders; (2) reduce stigma and its accompanying discrimination and discriminatory practices as much as possible; and most importantly (3) prevent continued stigma through developing, updating, and disseminating mental health education programs that are culturally relevant as well as empowering for the patient, their family, and their community. Change agents should partner with culturally diverse patients and patient populations to assist them in the development of a comprehensive assessment and plan that will preserve and respect their culture and decrease public, self, and structural stigma:

1 Consider culture and cultural influences on the values, lifeways, and behaviors of patients.
2 Promote patient empowerment and advocacy, as understood within diverse cultures and socioeconomic systems.

3 Engage with the immediate needs and agendas at hand in diverse communities.
4 Engage in anti-stigma activities that target consumers, communities, care providers, and policy makers.
5 Include health care education, as part of the overall treatment plan, including mental health care specific education, which is individualized to the patient's health care literacy needs, goals and cultural context.
6 Provide a plan for access to necessary information and culturally congruent resources for promoting, maintaining, sustaining mental health.
7 More effectively use the human capital available for providing mental health services through task shifting, management, and supervision of non-specialist mental health workers.
8 Use the economic, logistic, political and religious practices of the patient's culture and of the region to deliver culturally congruent treatment services.
9 Understand the political systems that regulate the transportation, economic, medical, and information services for the patient to provide relevant and congruent point of care treatment.
10 Support the patient's positive mental health, obtaining timely, effective treatment when needed, to preserve functional ability and overall productivity.
11 Protect the rights, responsibilities and decision-making of the patient.

Summary

An ecological model was used to guide the examination of the implications of culture and stigma on the mental health of populations, as well as the cultural-based attitudes, values, and beliefs that affect the responses of individuals and communities to these influences. Understanding cultural influences on patient behaviors as well as the provider's responses, improves the nurses' ability to best respond to patient needs, and to assist them in reaching their personal health goals. Therefore, being able to appreciate and understand the cultural context of individuals who receive mental health services is an essential professional competency.

Mental health is a social justice issue. Nursing practice must incorporate principles related to global mental health, including mental capital, social capital, access, equity, and political responsibility, in order to practice in a culturally relevant manner. Also, since stigma is a universally experienced occurrence that decreases access to mental health services and negatively affects mental health outcomes, each patient should be assessed for the effects of stigma. Nurses should advocate for the development and use of evidence-based mental health policies when practicing in countries that do not have a mental health policy or mental health plan. These proficiencies and skills are necessary for ethical practice.

Lastly, developing and maintaining sensitivity to, and respect for, the patient's culture-based attitudes, values, beliefs, and behaviors are lifelong tasks. Cultural competency is a process, not an end result, which requires motivation, self-awareness, and self-examination, a search for and use of knowledge, and a genuine desire to understand the patient from his/her perspective and experience. The culturally competent nurse provider of psychiatric and mental health care to facilitate assessment, interaction, education, and follow-up treatment should use local, national, and global resources. These resources include continuing education, support, and engagement from select mental health and nursing professional organizations, development and use of clinical guidelines for assessment and treatment, and ongoing feedback from the targeted population themselves. Use of these resources, coupled with nurses' understanding of and respect for the patient's cultural context is essential for delivery of comprehensive, appropriate mental health services, which include assessment, diagnosis, episodic and ongoing treatment, and long-term follow up with support and relevant linkages.

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