UNIT 3. Welcome and introductions

In this unit, you will examine evidence from **scientific literature** and learn about **established frameworks** for culturally competent care. These include the LEARN model, the Culturally Competent Community Care (CCCC) model or 4Cs), patient-centred cultural care, and intersectional approaches.

These frameworks are not rigid rules. Whether you're an educator or a support worker, these approaches can help you to communicate more effectively, build trust and respond to the needs of diverse individuals and communities.

Some content might challenge your assumptions or bring up strong emotions. That’s okay. Take your time, reflect and return when ready.

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UNIT 3. Evidence-based frameworks for culturally competent care

Research in mental health and education highlights the value of using evidence-based frameworks to support culturally competent practice. These tools help educators and support workers to communicate effectively, respond to diverse needs and reflect on their own biases. In this unit, you will examine practical frameworks like:

- LEARN - a model for cross-cultural communication.
- Patient-centred and culture-centred care - approaches that focus on individual needs and values.
- 4Cs model - linking training with real-life outcomes.
- Intersectionality - understanding how overlapping identities affect access to care.

These frameworks guide professionals beyond assumptions, offering structured ways to make learning and support inclusive, respectful and responsive. They help us to recognise that each person's experience is shaped by culture, background and social context - and that informed responses can make a real difference.

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UNIT 3. LEARN Model

The **LEARN model**, developed by Berlin and Fowkes (1983), is a practical framework structuring cross-cultural communication in clinical and educational settings. It stands for:

- **LISTEN**: Pay genuine attention with empathy to the individual's perceptions of their situation, listen without judgment or assumption.
- **EXPLAIN**: Share your perspective, while recognising that people may interpret health, learning or distress differently based on their cultural lens.
- **ACKNOWLEDGE**: Respectfully recognise and discuss both shared and differing views, promoting understanding and avoiding the imposition of one worldview.
- **RECOMMEND**: Offer solutions or next steps that integrate cultural context, preferences and values.
- **NEGOTIATE**: Reach a mutually acceptable plan, co-created with the individual or group and informed by both cultural and professional perspectives.

Using **LEARN** can help educators and support workers to build mutual understanding and trust, reducing miscommunication and improving engagement and outcomes

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UNIT 3. LEARN Model in practice

Scenario: Educator working with an Afghan adult learner in a mental health awareness session.

- **Listen:** The learner shares that they believe sadness is caused by spiritual disconnection.
- **Explain:** The educator explains how the session addresses emotional health and coping tools.
- **Acknowledge:** The educator validates that spiritual beliefs are important and can co-exist with self-care practices.
- **Recommend:** Suggests mindfulness and offers culturally adapted resources.
- **Negotiate:** Together, they agree to include spiritual well-being as a discussion topic in the next session.

This model can help educators and support workers to build trust and promote engagement.

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UNIT 3. Patient-Centred Care

Patient-centred care is defined by the Institute of Medicine (IOM, 2001) as care that respects and responds to individual patients' values, needs and preferences, actively involving them in decision-making. It emphasises:

- **RESPECT FOR INDIVIDUALITY**: Recognising the patient (or learner) as a whole person with their own experiences, beliefs and support systems.
- **SHARED DECISION-MAKING**: Collaboratively developing care or educational plans with the individual, rather than imposing directives.
- **EMPATHY AND ENGAGEMENT**: Prioritising communication that is warm, respectful and empowering, thereby promoting trust and therapeutic alliance.

Evidence shows that patient-centred approaches improve satisfaction, outcomes and cost-effectiveness across multiple healthcare and educational contexts. This applies to both teaching and support work, i.e., whether you're facilitating a workshop or helping a migrant access mental health services.

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UNIT 3. Patient-Centred Care in practice

Scenario: Support worker helping a recently arrived Somali woman navigate stress and isolation.

- **Understand the learner/client's values:** She values community support and religious coping.
- **Build rapport:** The support worker takes time to understand her life story and avoids assumptions.
- **Respect preferences:** Rather than suggesting therapy immediately, the support worker explores informal community supports first.
- **Empower decision-making:** Encourages the client to choose between community groups, online psycho-education or individual sessions.

Patient-centred care is about honouring autonomy and building a care plan around the person's life context.

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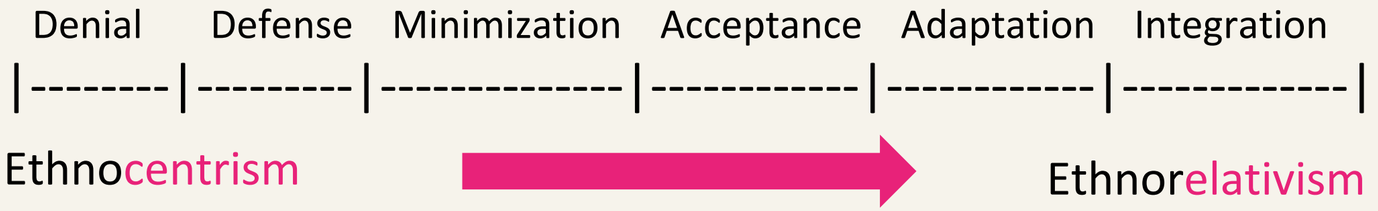
UNIT 3. The Developmental Model of Intercultural Sensitivity.

DMIS: Awareness → Perspective-Taking → Adaptation

The **Developmental Model of Intercultural Sensitivity (DMIS)** was developed by Milton J. Bennett (1986). It is a widely used framework to describe how people experience and engage with cultural differences. Rather than treating cultural competence as a fixed skill, Bennett conceptualised it as a developmental process that unfolds through stages.

The DMIS suggests that individuals progress from ethnocentric stages, where their own culture is seen as central and superior, to ethnorelative stages, where cultural differences are recognised, respected and integrated into behaviour and decision-making.



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UNIT 3. The Developmental Model of Intercultural Sensitivity.

Stages of DMIS:

Ethnocentric orientation:

1) Denial: little awareness of cultural differences.
2) Defence: cultural differences are perceived as threatening; emphasis on the superiority of one's own culture.
3) Minimisation: differences are downplayed; the assumption that deep down "we are all the same."

Ethnorelative orientation:

1) Acceptance: recognition and respect for cultural differences.
2) Adaptation: ability to shift perspective and adjust behaviour to different cultural contexts.
3) Integration: the capacity to move fluidly among cultural perspectives and build a multicultural identity.

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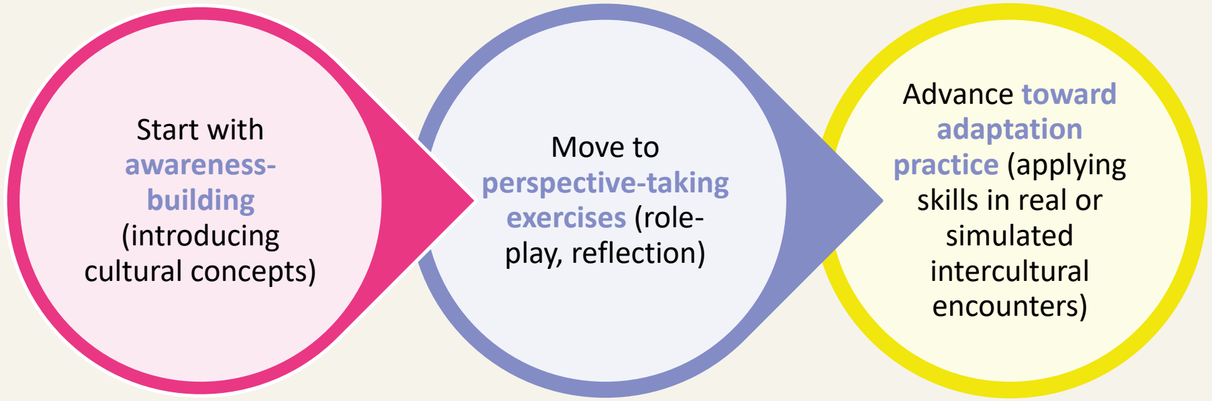
UNIT 3. The Developmental Model of Intercultural Sensitivity

Practical Application:
In education and training, DMIS helps structure learning as a stepwise sequence:



This staged approach ensures that learners develop cultural competence progressively, avoiding the assumption that a single workshop or session can create lasting change.

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UNIT 3. The Developmental Model of Intercultural Sensitivity in practice

Scenario: Educator running a group session with learners from diverse backgrounds.

- **Recognising your own stage:** The educator notices they've been operating in a "Minimisation" stage - treating all students the same to be "fair."
- **Growth moment:** A learner from Syria mentions the stigma of mental illness in her community.
- **Adaptation:** The educator adjusts the session to explore stigma across cultures, encouraging multiple perspectives and sharing.

DMIS is a reflective tool that helps practitioners grow in their cultural responsiveness.

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UNIT 3. The CCCC Model: Culturally Competent Community Care

The **Culturally Competent Community Care (CCCC) model** was developed by Kim-Godwin, Clarke & Barton (2001) in the Journal of Advanced Nursing. It is one of the most influential frameworks for linking cultural competence theory with practical outcomes in healthcare and education.

The model emphasises that culturally competent care requires more than good intentions.

It identifies four interrelated dimensions that professionals need to develop and apply consistently:

- Caring: demonstrating empathy, respect and commitment to the well-being of individuals and communities.
- Cultural Sensitivity: being aware of and responsive to cultural differences without stereotyping or judgment.
- Cultural Knowledge: acquiring factual and experiential understanding of cultural values, health beliefs and practices.
- Cultural Skills: applying knowledge and sensitivity in practice through effective communication, assessment and intervention strategies.

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UNIT 3. The CCCC Model: Culturally Competent Community Care

Practical Application

The strength of the CCCC model is its focus on measurable outcomes. Educators and support workers can use it to:

Through combining caring attitudes, cultural knowledge and applied skills, the CCCC model provides a comprehensive roadmap for culturally responsive practice.

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UNIT 3. The CCCC Model in practice

Scenario: Support worker collaborating with a migrant community leader to organise a mental health info day.

- **Caring:** Builds a relationship with the leader based on mutual trust.
- **Sensitivity:** Adjusts materials for language level and uses community metaphors.
- **Knowledge:** Understands local mental health taboos and traditional healing views.
- **Skills:** Facilitates the session in a way that invites stories, avoids clinical jargon and uses visual aids.

This model encourages a community-based, inclusive approach.

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UNIT 3. Intersectionality Framework

The term intersectionality was introduced by Kimberlé Crenshaw (1989, 1991) in the field of legal studies and critical race theory. It describes how different forms of identity and oppression, such as race, gender, class, legal status, language and sexual orientation, intersect and create unique experiences of inequality. Intersectionality challenges single-axis analyses (e.g., focusing only on ethnicity or only on gender) by showing that multiple systems of power and exclusion operate simultaneously.

In medical and educational contexts, Powell Sears (2012, Medical Education) argued that cultural competence training should adopt an intersectional framework. The rationale is that it is not enough to address cultural differences one dimension at a time (e.g., ethnicity alone). Instead, professionals must recognise how multiple structural and identity factors interact to shape: mental health outcomes, access to services and educational participation.

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UNIT 3. Intersectionality Framework

Implications for Practice

An intersectional approach requires moving beyond individual interpersonal skills and addressing structural barriers such as:

- Language access.
- Legal status and migration policy.
- Institutional racism and discrimination.
- Socioeconomic deprivation and poverty.

Thus, professionals should not only think of different communication techniques but also have a critical awareness of systems and policies that affect learners' well-being.

What systemic factors might affect your learners or clients that go beyond culture alone?

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UNIT 3. Intersectionality Framework in practice

Scenario: Educator notices that a young trans asylum seeker from Nigeria is disengaged in class.

- **Multiple layers at play:** Their identity as a migrant, LGBTQ+ person and trauma survivor intersect.
- **Application:** The educator reflects on potential systemic barriers (e.g., fear of discrimination, safety concerns) and adjusts their approach by:
  - Allowing anonymous participation in discussions.
  - Addressing inclusion and safety in group norms.
  - Collaborating with trusted NGOs and other organisations.

Intersectionality helps uncover invisible struggles that shape participation.

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UNIT 3. Bringing the Frameworks together

Culturally competent practice in mental health education is **most effective** when **multiple evidence-based frameworks are combined**, as each model contributes a unique perspective. No single framework is sufficient on its own. Through integrating different models, educators can design training that is:

- Respectful and inclusive at the individual level.
- Structured and evidence-based at the pedagogical level.
- Aware of inequalities and barriers at the systemic level.

Together, these frameworks provide a comprehensive toolkit for culturally competent and impactful mental health education.

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UNIT 3. Combining Frameworks in practise

Scenario: You are preparing a mental health workshop for newly arrived adults from several countries.

- Use DMIS to assess your own development and cultural biases.
- Apply LEARN when interacting with participants who challenge your views.
- Ensure your approach is patient-centred - start with their needs, not your assumptions.
- Integrate CCCC by building trust and tailoring your resources.
- Apply intersectionality to adapt for overlapping issues (e.g., gender, migration status, trauma).

These frameworks are not separate. They complement each other to help you support people with empathy, respect, and cultural understanding..

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