

11-13-2025

Staff Education to Improve Cultural Competence in Mental Health Care

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Walden University

College of Nursing

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Mariam Farah

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and that any and all revisions required by
the review committee have been made.

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Walden University

2025

Executive Summary: Staff Education Project
Staff Education to Improve Cultural Competence in Mental Health Care

by

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BS, Minnesota State University, Mankato, 2020

Executive Summary Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Nursing Practice

Walden University

November 2025

Summary

This doctoral project addressed a gap in staff cultural competence at a mental health and addiction services center in the Midwest. I conducted this project to design, implement, and evaluate a staff educational program to improve staff knowledge, cultural awareness, and communication skills. The guiding practice-focused question was: Among staff at the Midwest mental health and addiction services center, how does a structured cultural competence education program compare to current practices in improving staff knowledge of cultural awareness?

A 2-day educational session was held to accommodate participation within regular work schedules without interfering with the project site organization's services. Arrangements included half of the staff attending first day, and the remaining staff on the second day. Interactive lectures, case studies, role-playing, and guided reflection were all part of each 2-hour session. In addition to anonymous feedback surveys, quizzes were initiated before and after the education session. The results showed meaningful gains in knowledge, with 86% of staff showing quantifiable improvements and average quiz scores rising from 65% to 87%. An increased awareness of bias, improved confidence in cross-cultural communication, and an appreciation for role-playing as a practical teaching technique were shown in the qualitative results.

The results of this project indicated that structured cultural competence education can enhance staff's cultural competence when delivering culturally sensitive care. This project strengthened staff skills and supported organizational goals to promote equity and engage in inclusive practices that embrace patient diversity in care delivery, contributing to positive social change.

Background

In ethnically diverse settings, cultural competence is crucial for establishing trust, communicating efficiently, and delivering patient-centered care. The lack of structured, cultural competency education at the project site contributed to miscommunication with East African patients. A growing evidence base indicates that formal cultural competence education improves provider knowledge, communication, and patient experiences. Zeidani et al. (2023) found that nurses' cultural sensitivity improved significantly after engaging in focused communication and cultural competency training. Farsangi et al. (2023) reported that app-supported curricula increased humility and self-awareness among learners. Among nursing students, structured modules improved readiness for culturally responsive practice (Ličen & Prosen, 2023), and localized cross-cultural education raised readiness-for-diversity scores among medical staff (Lu et al., 2020).

Furthermore, a range of practice standards endorse educational programs that link cultural identity to therapeutic rapport and satisfaction (Nair & Adetayo, 2019). Stubbe (2020) emphasized that cultural competence must be paired with cultural humility, encouraging providers to acknowledge their biases and remain open to learning from patients. When providers integrate both approaches, they can foster a mutual respect between patients from diverse backgrounds, empathy for them, and a collaborative relationship with them. According to Kaihlanen et al. (2019), qualitative research, prelicensure programs, and workplaces need to provide staff with education on how to work with diverse populations.

I used an evidence-based practice model developed by the Johns Hopkins Health System (Dang et al., 2022) to support the implementation of an interactive, structured

program to improve staff communication and knowledge in multicultural mental health care. Kaihlanen et al. (2019) further delineated the importance of cultural competence education both in nursing education and clinical practice settings to facilitate long-term awareness and skill development. Their findings support broader research advocating ongoing and structured learning opportunities for healthcare providers. This evidence was rated strong and compelling using the Johns Hopkins evidence-based practice model (see Dang et al., 2022).

I collected the data for this project using an education needs assessment (see Appendix A) prior to the education session (see Appendix B for an outline of the modules and Appendix C for the case-study). I used pre- and posteducation knowledge quizzes, reflection questionnaires, and anonymous satisfaction surveys (see Appendices D–E). To determine changes in mean scores and recurrent themes from qualitative reflections, the data were analyzed quantitatively using descriptive statistics. I also conducted an evaluation process to determine if the teaching effectively achieved its intended results by assessing learning acquisition and staff response. Through both quantitative and qualitative measures, a complete assessment of the effectiveness of the education program was conducted.

Staff Education Project Development

Project Planning and Leadership Engagement

To begin the project process, I approached the site leader to explain the importance of cultural competency and the need to educate staff about cultural diversity. It was essential to take the leader through the plan and present evidence from the project site workplace to demonstrate why addressing this gap in practice was crucial. It was

particularly helpful to include evidence of the diverse patient population of this facility in the presentation.

When the site leader and management approved the project, I informed staff members about the staff education session and that it would occur during work hours. Preparing staff ahead of time ensured there was no lapse in care between scheduled sessions at the treatment center. Staff were prepared, knowing they would be covering half of their colleagues during education sessions each day. This approach worked well and contributed to an effective education day.

I provided the educational materials, including quizzes, reflection worksheets, and feedback surveys, in paper form at each session (see Appendix F for the evaluation matrix). Seven sets of numbered forms were placed on a table at the front of the room before participants arrived. Participants were instructed to pick up a set that had a small identifying number on the top right corner. To protect anonymity, I only used this number for matching the participants' pre- and posteducation results. No names, job titles, or demographic information appeared on any materials. The forms were deposited in a collection bin that could only be accessed by me after they had been completed by the participants. In accordance with Walden University's guidelines for the DNP project, participation was voluntary, and the completion of the materials indicated consent. I summarized the quantitative results using descriptive statistics (mean changes) and coded the qualitative reflections for recurring themes in cultural awareness, communication, and confidence. In this project, quantitative and qualitative data were collected to evaluate program outcomes rather than conducting a mixed-methods study.

Participants and Setting

A total of 14 staff members attended the education sessions, including two registered nurses, one licensed alcohol and drug counselor, one licensed independent clinical social worker, 10 case managers, and support staff. Attendance was tracked only by participant number to maintain anonymity (see sample form in Appendix G). At the start of each session, I placed seven complete sets of numbered forms on a table at the front of the room. Each form had a small number written in the upper-right corner. Participants were told to take one set randomly. As a result of this process, each staff member received an individual number without identifying characteristics. This enabled a confidential comparison of pre- and posteducation results.

The site leader organized the use of a conference room for education. Education took place over 2 consecutive days, with half of the staff attending Day 1 and the rest attending Day 2. To encourage participation and attendance, I provided light snacks, including donuts, mint candy, and drinks. The teaching materials included case studies, quizzes, and reflection forms (see Appendices C–E). Furthermore, I briefed staff on the program's goals and confidentiality protocols.

Education Implementation

In-person education, led by me, occurred over 2 days. On both education days, staff participated in 2-hour sessions covering two modules. The first module emphasized cultural identity, bias, and awareness. Interactive education reduced tension and stress, and different workplace examples were used. I asked participants to identify and describe the situations or challenges they faced and how they dealt with them. It was essential to

determine whether the staff understood the primary meaning of diversity during this process.

The second module focused on communication strategies and culturally responsive interactions. Activities included interactive lectures, case study analysis, role-play, and personal reflection (see Appendices B–C). The session emphasized an interactive approach where participants shared their experiences. The diversity of the staff was beneficial because it improved the quality of discussions and made them more informative. Staff from different backgrounds shared their experiences, enhancing learning and the intended goal of the staff education project.

Evaluation and Documentation

An evaluation matrix is in Appendix F. Pre- and post-education quizzes, which included short-answer reflection questions, encouraged staff to connect the material to their practice (see Appendix D). Meanwhile, feedback forms allowed staff to provide suggestions and feedback (see Appendix E). In accordance with Walden guidelines, I documented attendance at the start of each education session without collecting demographic information (see Appendix G).

Results

The participants' pre- and posteducation quizzes (see Appendix D) showed a significant improvement in their knowledge. After the education session concluded, the average score increased from 65% to 87%. Staff education achieved its goals as demonstrated by the 12 participants who experienced personal gains (see Table 1). For the scoring rubric, each quiz consisted of three questions, totaling 10 points. Questions 1 and 2 were worth

four points each, and Question 3 was worth two points. Each response was rated using a rubric: 0 = incorrect, 1 = partially correct, and 2 = complete.

Table 1

Pre- and Posteducation Quiz Results (N = 14)

| Measure | Preeducation <i>M</i> (%) | Posteducation <i>M</i> (%) | <i>n</i> improved | % improved |
|-----------------|---------------------------|----------------------------|-------------------|------------|
| Knowledge score | 65 | 87 | 12/14 | 86% |

Note. Scores represent staff performance on pre- and postintervention quizzes. 12 of 14 participants demonstrated measurable improvement.

Table 2

Individual Pre- and Posteducation Quiz Scores (N = 14)

| Participant | Prequiz (%) | Postquiz (%) | Change (%) |
|-------------|-------------|--------------|------------|
| 1 | 60 | 90 | +30 |
| 2 | 70 | 90 | +20 |
| 3 | 65 | 85 | +20 |
| 4 | 50 | 80 | +30 |
| 5 | 60 | 85 | +25 |
| 6 | 70 | 85 | +15 |
| 7 | 65 | 90 | +25 |
| 8 | 55 | 80 | +25 |
| 9 | 60 | 85 | +25 |
| 10 | 65 | 85 | +20 |
| 11 | 70 | 90 | +20 |
| 12 | 55 | 75 | +20 |
| 13 | 60 | 85 | +25 |
| 14 | 65 | 85 | +20 |
| <i>M</i> | 65 | 87 | +22 |

Note. Participant numbers correspond to attendance records in (see Appendix G).

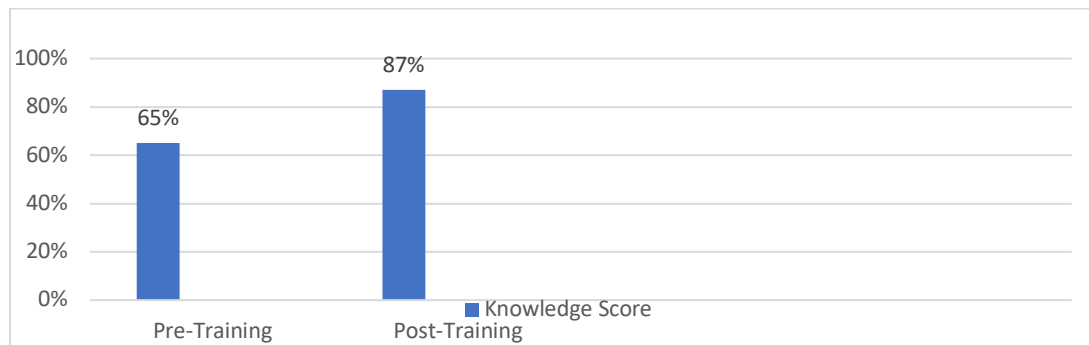
Based on participants' short-answer reflection responses, three primary themes emerged: Participants expressed greater awareness of their biases, showed greater confidence in communicating across cultural divides, and valued role-playing exercises

that helped them prepare to interact with patients. The qualitative findings confirm the quantitative findings by highlighting participants' knowledge gains and meaningful changes in their attitudes and abilities.

Feedback surveys (see Appendix E) indicated high satisfaction with the sessions, and participants recommended that they be included in the onboarding process and offered every 6 months as a refresher course. I found that the program enhanced cultural competence and aligned with the project site organization's mission to provide culturally sensitive, patient-centered care (see Figure 1).

Figure 1

Comparison of Pre- and Posteducation Knowledge Scores



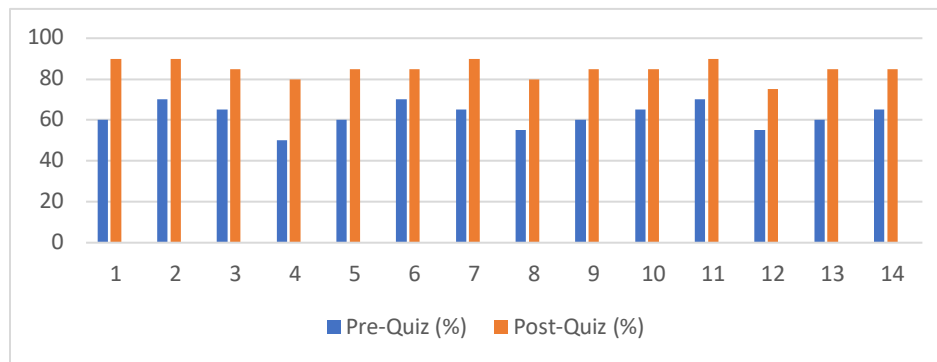
Note. Knowledge scores were based on a 10-point quiz evaluating staff understanding of cultural competence concepts (see Appendix F for the evaluation matrix).

To summarize, I conducted two sessions as part of the cultural competence education program. The program improved staff's knowledge and confidence in working with the East African immigrant community. As a result of the education, participants' quizzes showed a 22% mean increase in knowledge, from 65% to 87% as noted in Table 1. The qualitative feedback validated the quantitative gains (see Appendices D–E), including personal bias acknowledgment and improved communication with clients of

diverse ethnicities (see Appendix C). Based on the results, the structured education intervention enhanced staff competence and preparedness to provide culturally appropriate care within behavioral health and addiction treatment settings.

Figure 2

Individual Participant Pre- and Posteducation Quiz Scores (N = 14)



Note. Figure 2 illustrates pre- and posteducation quiz scores for all 14 participants. 12 participants (86%) showed measurable improvement; the mean score increased from 65% to 87%.

Limitations

The project had several limitations, including the small sample size ($N = 14$), which limits broader application outside the organization. I conducted the project at a single Midwestern site, which limits its application to other healthcare settings. The project's time constraints restricted the education to two 2-hour sessions, omitting long-term follow up. Lastly, self-reported reflections and surveys may have introduced bias. However, the project demonstrated significant improvements in participants' cultural competence despite these limitations.

Implications for Nursing Practice

This project emphasizes the importance of cultural competence education in staff development and standard nursing practice. The ability to recognize cultural differences can facilitate therapeutic involvement, lower communication barriers, and enhance equity of care for nurses and allied health professionals. The inclusion of cultural education into professional orientation and ongoing professional development is essential for supporting diversity, equity, and inclusion standards. Nurses serve as advocates for patients, ensuring that their care reflects the values and needs of the culture.

Implications for Positive Social Change

The purpose of this project was to address a gap in providing care in mental health and addiction treatment for East African immigrant and refugee communities, which contributes to Walden University's objective of constructive social change. The project enhances community well-being by promoting social justice in healthcare through culturally sensitive care delivery. By improving staff competency, health equity is promoted, patient-provider trust is increased, and inclusivity is facilitated.

Conclusions

I conducted this project to showcase how structured, interactive staff education can enhance cultural competency education. The education program improved staff knowledge, communication skills, and self-awareness. While the study had limitations, including a small sample size and a short education period, they did not overshadow the positive results.

The project site organization should integrate the cultural competency education into onboarding and hold a refresh course regularly. An expansion of the program to

include scenarios for other cultural groups might further improve staff readiness.

Education can lead to improved patient engagement and equitable care delivery.

Furthermore, the project reinforces nurses' responsibility to advocate for patient-centered care. The project strengthens Walden University's mission of positive social change by addressing disparities, promoting inclusivity, and advancing health equity in mental health services.

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Appendix A: Section 1: Education Needs Assessment

Cultural Competence Education Needs Assessment

Job Title: _____

Years of Experience: _____

Previous Cultural Competence Education: Yes No

Knowledge and Awareness

1. How confident are you in interacting with patients from different cultural backgrounds?
 - a) Very confident
 - b) Confident
 - c) Neutral
 - d) Not confident
 - e) Not confident at all

2. How often do you encounter patients from cultural backgrounds different from your own?
 - a) Always
 - b) Frequently
 - c) Occasionally
 - d) Rarely
 - e) Never

3. How familiar are you with the concept of cultural competence in healthcare?
 - a) Very familiar
 - b) Somewhat familiar

- c) Neutral
- d) Not familiar
- e) Never heard of it

Skills and Application

4. Have you ever participated in any cultural competence education programs?
- a) Yes
 - b) No
5. What areas do you think are important for cultural competence education? (Select all that apply)
- a) Understanding cultural differences
 - b) Effective communication with diverse patients
 - c) Overcoming biases and stereotypes
 - d) Culturally sensitive healthcare practices
 - e) Other: _____
6. In your opinion, which area would benefit from more education? (Select one)
- a) Understanding cultural differences
 - b) Effective communication
 - c) Overcoming biases
 - d) Healthcare practices
 - e) Other: _____

Appendix B: Section 2: Education Modules (with Evidence Alignment)

Module 1: Introduction to Cultural Competence

Learning Objectives

- Define cultural competence and its importance in healthcare.
- Understand how cultural competence improves patient care and outcomes.
- Recognize the impact of culture on health beliefs, practices, and communication.

Content

- *Cultural competence in healthcare*: The ability to understand, communicate with, and interact effectively across cultures.
- *Importance*: Builds trust, improves satisfaction and adherence, and reduces disparities.

Activity

- *Case Study*: Participants analyze a scenario where cultural differences impacted patient care and propose culturally competent approaches.

Module 2: Communication Skills for Culturally Diverse Populations

Learning Objectives

- Learn effective communication strategies for interacting with diverse patients.
- Understand non-verbal communication cues across cultures.
- Develop skills to address language barriers.

Content

- *Effective communication strategies*: Clear language, attention to non-verbal cues, active listening.

- *Overcoming barriers:* Use interpreters, respect cultural norms around space, touch, and eye contact.

Appendix C: Case Study Activity

Participants reviewed a clinical vignette highlighting cultural misunderstandings in care delivery. Staff were asked to:

1. Identify potential barriers to communication.
2. Discuss culturally responsive strategies to address the patient's concerns.
3. Share examples of how similar situations might arise in their work.

Role-Play Activity

Staff practiced provider–patient interactions across cultural and language barriers. Role-play scenarios included:

- Scenario 1: A patient declines a recommended treatment due to cultural beliefs. Staff must respectfully explore the patient's reasoning and propose alternatives.
- Scenario 2: A patient with limited English proficiency expresses distress. Staff must effectively incorporate interpreter services and demonstrate culturally sensitive body language.
- Scenario 3: A family caregiver expresses concern about gender norms in care delivery. Staff must negotiate care strategies while respecting cultural values.

Note. These scenarios were designed to encourage staff to apply cultural competence skills in realistic, practice-based interactions.

Appendix D: Assessment Tools

Preassessment Quiz

1. True or False: Cultural competence means being able to understand and interact effectively with people of all cultures.
2. Multiple Choice: Which of the following is an example of cultural competence in healthcare?
 - a) Ignoring a patient's cultural background to focus on medical treatment.
 - b) Asking a patient about their cultural preferences during a consultation.
 - c) Assuming all patients from the same culture have the same needs.
 - d) None of the above.
3. Short Answer: Describe how cultural competence might impact the care you provide to a patient from a different cultural background.

Postassessment Quiz

1. Multiple Choice: After completing this education, you should feel more confident in:
 - a) Understanding cultural differences and their impact on healthcare.
 - b) Communicating with patients from diverse backgrounds.
 - c) All of the above.
 - d) None of the above.
2. True or False: Cultural competence can only be developed through years of experience, not education.
3. Short Answer: Reflect on one change you will make in your practice to improve cultural competence.

Appendix E: Participant Feedback Form

Thank you for participating in this education on cultural competence. Please provide your feedback to help us improve future sessions.

1. The education objectives were clear.
 - Strongly Agree Agree Neutral Disagree Strongly Disagree
2. The education content was relevant to my work.
 - Strongly Agree Agree Neutral Disagree Strongly Disagree
3. The activities (case studies, role-play, reflection) were useful and engaging.
 - Strongly Agree Agree Neutral Disagree Strongly Disagree
4. The length of the education was appropriate.
 - Strongly Agree Agree Neutral Disagree Strongly Disagree
5. I feel more confident in applying cultural competence in my role.
 - Strongly Agree Agree Neutral Disagree Strongly Disagree

Open-Ended Questions:

- What part of the education was most helpful?
- What could be improved?
- Additional comments: _____

Appendix F: Evaluation Matrix

Evaluation Matrix: Instruments, Purpose, and Analysis

| Instrument | Appendix | Purpose | Time | Data Type | Tabulation /Analysis |
|-----------------------------------|-----------------|------------------------------|---------------|---|---------------------------------|
| Pre-Quiz | D | Baseline Knowledge | Session Start | Quant | Rubric score → % mean |
| Post-Quiz | D | Knowledge Gain | Session End | Quant | Compare to pre-quiz; % improved |
| Short-answer reflection worksheet | D | Connect learning to practice | Session End | Qual | Rapid coding to themes |
| Feedback Survey | E | Satisfaction & confidence | Session End | Mixed | Likert means; theme grouping |
| Attendance | G | Verify participation | Session Start | Documented by DNP student; attendance count verified for compliance | Count/Compliance |

Appendix G: Sample Staff Education Attendance Sheet

Education: Cultural Competence Education

Dates: Day 1 or Day 2

Facilitator: Mariam Farah, RN

| Participant # | Attended (Day) |
|---------------|----------------|
| 1 | Day 1 |
| 2 | Day 1 |
| 3 | Day 1 |
| 4 | Day 1 |
| 5 | Day 1 |
| 6 | Day 1 |
| 7 | Day 2 |
| 8 | Day 2 |
| 9 | Day 2 |
| 10 | Day 2 |
| 11 | Day 2 |
| 12 | Day 2 |
| 13 | Day 2 |
| 14 | Day 1 |

Note. Attendance is tracked only by non-identifiable participant numbers to maintain confidentiality. No job titles, signatures, or demographic identifiers were recorded.