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Guidelines for Training in Cultural Psychiatry

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Introduction

Canada is a highly diverse society and Canadian scholars and clinicians have been world leaders in efforts to understand the impact of culture on mental health. However, to date, there have been no national guidelines for the integration of culture in psychiatric education and practice. This paper, prepared by the Section on Transcultural Psychiatry of the Canadian Psychiatric Association (CPA) for the Standing Committee on Education, sets out the rationale, content and pedagogical strategies for training in cultural psychiatry. It is based on a review of literature, experiences with existing training programs and expert consensus. This paper addresses issues relevant to general psychiatry as well as specific populations, including immigrants, refugees and ethnocultural communities as well as First Nations, Inuit and Métis.

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Background

There is a large literature demonstrating the many ways that cultural variations affect the symptomatic manifestations and clinical presentation of the entire range of mental health problems, including common mental disorders, such as depression, anxiety and trauma-related problems, as well as psychosis and organic mental disorders.[1,2] These cultural variations have been shown to influence physicians' ability to detect, diagnose and appropriately treat mental health problems. Cultural differences in health practices are also major determinants of illness behaviour, coping, treatment response and adherence, rehabilitation and recovery. There is strong evidence that cultural differences contribute to health disparities and unequal access to care and that cultural knowledge and identity are important determinants of treatment outcome.[3–8] Any mental health care system that aims to achieve equity must therefore address issues of cultural diversity.[9] This has been recognized by governmental and professional organizations in the United States, the United Kingdom, Canada and other countries.[3,10,11]

The Mental Health Commission of Canada, in its framework for a mental health strategy, included addressing the diverse needs of Canadians as the third of seven basic principles of a reformed mental health care system.[12] These diverse needs include those arising from culture and ethnicity, as well as from gender, sexual orientation, disability and other aspects of experience that interact with cultural values.

Cultural diversity is conceptualized in different ways in different countries based on local histories of migration, policies and ideologies of citizenship, and patterns of ethnic identity and social stratification.[13–17] The Canadian context is distinctive in many ways. Since 1976, Canada has had an official policy of multiculturalism.[18] This formally acknowledges and promotes recognition of the diversity of Canadian society as a shared feature of collective identity.[19] It reflects and contributes to a social milieu in which attention to culture is positively valued and, indeed, required to respect and respond to individuals and ethnocultural communities. However, this explicit commitment to diversity is relatively recent, and the education of professionals generally has ignored the history of Eurocentric and racist policies and exclusionary practices that continue to have impact on individuals and communities.[20–22] Recent years have seen greater recognition of the history of colonization and the devastating impact of the policies of forced assimilation on Aboriginal Peoples in Canada, along with appreciation of the resilience and vitality of First Nations, Inuit and Métis cultures, languages and traditions as resources for mental health and well-being.

Although Canada has been a culturally diverse nation from its inception, the geographic origin of newcomers to Canada has changed. Before 1960, more than 90 per cent of immigrants were from Europe; by 2006, this had dropped below 19 per cent. At present, most of the more than 250,000 people who come to Canada each year are from Asia, Africa, the Middle East and Latin America—regions with great internal diversity and significant differences from the European cultures prevalent in earlier waves of migration. This new migration, in concert with recent geopolitical events, has challenged the complacency of multiculturalism, drawing attention to persisting and new forms of inequality that affect the mental health and access to services of Canada's population. Understanding these issues is crucial for the training of psychiatrists and other mental health professionals.

Existing Training Programs and Initiatives

There have been significant efforts in the United States, the United Kingdom and Australia to develop training guidelines and materials to enhance clinicians' cultural competence. Most medical schools in Canada address general themes, including the doctor–patient relationship, socioeconomic status and racism, and provide information about the ethnocultural communities they serve, but few give adequate attention to issues of health care access or language.[23]

Models of training based on the configurations of cultural identity in the United States are based on the five ethnoracial blocs defined by the US census (African American, Asian American and Pacific Islanders, Hispanic, American Indian and Alaskan Native, and White).[14] This clustering of diverse groups into major blocs has greatly facilitated advocacy efforts of minority groups in the United States.[24] Many programs provide trainees with sessions led by representatives of these communities. While this fosters a basic level of recognition of diversity, it may have the unintentional effect of downplaying the heterogeneity and diversity subsumed under these major blocs and reinforcing crude stereotypes. Moreover, education based on broad cultural or geographic groups cannot address the high level of diversity in Canadian contexts, where the demographic composition is generally not that of large ethnocultural blocs but rather many smaller heterogeneous communities, including significant numbers of Aboriginal people and refugees.[25] To respond to the diversity in Canada's urban centres, clinicians must develop general strategies for culturally safe, competent and responsive care that can be adapted to work with diverse groups.[14]

Surveys of training in cultural psychiatry in Canada have revealed uneven development across the country.[26] Most Canadian psychiatric residency programs offer very limited exposure to cultural psychiatry.[27] This reflects that, to date, regulatory bodies and organizations in Canada have not developed specific guidelines for training or clinical practice in cultural psychiatry. In the Royal College of Physicians and Surgeons of Canada (RCPSC) accreditation standards there is only brief mention that learning environments, teaching and evaluation must address "the acquisition of knowledge, skills, and attitudes relating to aspects of age, gender, culture and ethnicity appropriate to the specialty or subspecialty."[28, p 9] The objectives for psychiatry note that "In all aspects of specialist practice, the resident must be able to address issues of gender, sexual orientation, age, culture, ethnicity, spirituality and ethics in a professional manner."[29, p 1] A CPA position paper[30] on training for work in rural and remote areas makes brief mention of the importance of attention to local culture and of Aboriginal mental health issues. Earlier position papers[31,32] on training in emergency psychiatry and substance abuse both acknowledge the relevance of sociocultural factors; however, no detail on curriculum is provided.

Key Concepts

There have been substantial advances in cultural psychiatry in recent years that can inform a basic curriculum. Work in developing curriculum, didactic methods and resources for training has been conducted at several universities in Canada.[33–38] In this section, we summarize key concepts for a core curriculum.

Culture, Race and Ethnicity

The notion of culture covers a broad set of meanings that have shifted with changes in the configuration of societies and in our understanding of the nature of communities and traditions.[39] Culture includes all of the socially transmitted aspects of a way of life, from values and knowledge to social behaviours and practices. As such, institutions and professional bodies of knowledge and practice such as psychiatry are also imbued with culture. Cultures produce forms of identity, including race and ethnicity. Race is a social marking of identity, usually based on appearance that is attributed to some presumed intrinsic characteristic of a group.[40–42] Although there is no coherent biological definition of race, it is of importance in psychiatry mainly because racism and practices of social discrimination, exclusion and oppression can have very adverse effects on mental health and the way that groups interact with health services.[43] Ethnicity refers to the ways in which groups identify themselves as historical peoples or communities.[44] The dynamics of culture, race and ethnicity depend on interactions among groups within a larger society. Canada has its own unique history and dynamics relevant to identity and mental health.[45]

Cultural Biology and Cultural Neuroscience

Older notions of culture defined it in contrast to (human) nature, which was assumed to be rooted in a universal biology. There is increasing recognition that there are local biologies that reflect culturally mediated differences in human populations.[46] These may contribute to pharmacokinetic and possibly pharmacodynamic differences in medication response.[47] The emerging field of cultural neuroscience reveals ways in which differences in child-rearing or social contexts influence neuropsychological mechanisms of attention, memory, cognition and emotion, self-representation and psychopathology.[48,49]

Social and Cultural Determinants of Health and Health Disparities

Cultural differences result in particular social statuses, identities and positions that are associated with varying exposure to particular types of social determinants, adversity and access to resources, including health services.[50] This results in substantial disparities in the prevalence of specific mental health problems and health outcomes.

Racism, Prejudice and Discrimination

Among the most important social determinants of health are systematic exposure to discrimination and exclusion that may be associated with racist ideologies, or subtler forms of bias and discrimination, both at an individual level and as part of institutional practices.[43,51,52] These result in structural inequalities as well as in everyday practices of denigration that may involve forms of microaggression.[53]

Institutional Racism

Defined as institutional failures to provide appropriate care and services because of culture, ethnic origin or race, institutional racism is a particular concern in mental health care settings. Even where individuals are not explicitly racist, institutional racism can be seen or detected in attitudes and behaviours that amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and stereotyping that can disadvantage people in a minority group.[54,55]

Migration, Colonization and Mental Health

Migration and colonization may involve rapid culture change. When such change is forced and undermines core cultural values, it may contribute to acculturative and social stress, identity conflicts, family conflict and other mental health issues.[56]

Cultural Influences on the Mechanisms of Psychopathology

Culture may contribute directly to the underlying mechanisms of psychopathology by influencing the neurobiology of mental disorders through developmental experiences, diet and other aspects of behaviour, as well as by shaping the form and content of cognitive and interpersonal processes.[57,58] Examples include the diverse types of panic disorder that depend on culture-specific interpretations of sensations,[59] and the variations in the form and prevalence of dissociative disorders reflecting the use of dissociation in religious and healing traditions.[60]

Illness and Help-Seeking Behaviours

Cultural interpretations of sensations, symptoms, illnesses and other types of problems guide coping, help seeking and health care use.[57] Independent of their contributions to the mechanisms of psychopathology, cultural knowledge and practices are therefore important considerations in improving access to health care, recognizing and responding appropriately to patients concerns, negotiating treatment and ensuring adherence.

Cultural Competence and Cultural Safety

Various frameworks have been developed to address the organization and delivery of mental health services in ways that are respectful of and responsive to the unique social, cultural and political situations of different groups.[61] Much of this work has been framed in terms of notions of cultural competence, which includes awareness of the impact of the clinician's own ethnocultural identity on patients; knowledge of the language and cultural background of groups seen in clinical practice and their interactions with mental health issues and treatment; the skills for working with particular groups; and the development of an organization or system that is capable of offering equity of access and outcome to diverse populations.[62–64] In addition to cultural competence, the Mental Health Commission of Canada has also embraced the framework of cultural safety, originally developed in New Zealand, which emphasizes the power differentials and vulnerability inherent in clinical situations involving dominant and subdominant groups in society.[65–67] Cultural safety builds on knowledge of historical and political experiences of oppression and marginalization to give explicit attention to structural and organizational issues that protect the voice and perspective of patients, their cultures and communities.

Clinical Assessment and the Cultural Formulation

The Outline for Cultural Formulation, introduced with the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), is a key tool for organizing clinically relevant cultural information into a diagnostic formulation.[68,69] Recent work has developed semi-structured interviews and detailed guidelines for conducting cultural formulation interviews with patients and their families.[70]

Working With Interpreters and Culture Brokers

More than 20 per cent of the population of Canada have a mother tongue that is not English or French. They may want or need to use these languages in times of crisis or distress. Effective communication is essential to accurate diagnosis and the negotiation and delivery of effective treatment. In situations where patients and clinicians are not fluent in the same language, safe and effective care requires the use of professional medical interpreters.[71] Practical constraints and professional attitudes contribute to a reluctance to use interpreters.[72] As a result, trained interpreters continued to be underused in health care. Even when linguistic communication is established, cultural formulation may require the use of culture brokers or mediators, that is, resource people or professionals with in-depth knowledge of the specific cultural and social background of the patient as well as knowledge of the medical systems who can function as go-betweens, brokering mutual understanding and collaboration. Interpreting in child psychiatry requires specific training, both for the clinician and the interpreter, to address the challenge of assessing development across cultures as well as intergenerational conflict within immigrant families.[73]

Policy Issues

The design and implementation of safe and competent mental health care systems and institutions requires attention to structural and organizational issues at multiple levels.[74] Overarching demographic patterns and social policies of immigration and integration shape these service responses. Human rights, multiculturalism, interculturalism and other approaches to diversity influence the legal and economic support for, as well as the feasibility and acceptability of, specific models of service organization.[75,76]

Global Mental Health and Human Rights

There is increasing recognition and effort to provide effective psychiatric services in low- and middle-income countries where mental health problems are major contributors to the burden of illness.[77] Cultural issues are central in efforts to export and adapt interventions. Recognition and respect for culture is essential to human identity and well-being, and hence is included as a fundamental human right. Culture itself raises complex ethical and human rights issues in the ways it defines such basic dimensions of social difference as developmental stage, gender and collective identity.

Aboriginal Mental Health

Aboriginal people constitute about four per cent of the Canadian population but bear a disproportionate burden of mental health problems.[78,79] Although there is wide variation across groups, the higher rates of psychiatric and substance abuse disorders found in many segments of the indigenous population can be linked to the enduring effects of historical social, economic and political policies of forced assimilation, marginalization and discrimination.[80–83] The Indian Act, the Indian Residential School system and the child welfare system have had profound effects on the mental health of Aboriginal populations.[84–86] However, Aboriginal individuals, communities and peoples have unique resources and strategies of resilience reflecting culture, language, spirituality and connections to family, community and place.[87]

There is wide recognition of the need for training in cultural competence to respond to the mental health needs of Aboriginal Peoples.[88,89] Many communities are located in remote regions, posing logistical problems in delivery of care that require consideration of specialized approaches, with close collaboration with community workers, mobile crisis and consultation teams, and telepsychiatry. More than 50 per cent of Aboriginal people live in cities where they may not have access to culturally appropriate services that respect and make use of their linguistic, cultural and spiritual traditions. The National Aboriginal Health Organization, the Aboriginal Nurses Association of Canada, and the First Nations, Inuit and Métis Advisory Committee of the Mental Health Commission of Canada identified cultural safety as an important framework for the development of training programs and institutional changes to improve the quality and appropriateness of mental health care.[90,91] Cultural safety focuses on the structural inequalities and power imbalances that make clinical encounters unsafe for Aboriginal people.[67,92,93]

Recently, the Indigenous Physicians Association of Canada and the RCPSC have developed core curriculum and clinical interviewing training materials for residents.[94,95] Training involves reading, discussion, role-playing and interaction with trainers from Aboriginal communities, to provide:

1. A basic understanding of the links between historical and current government practices and policies toward First Nations, Inuit and Métis Peoples and the social determinants of health, access to health services and intergenerational health outcomes.

2. Reflection on trainees' own cultural values and emotional responses to the history, identities and contemporary events involving First Nations, Inuit and Métis.

The curriculum developed for family medicine residents also addresses specific clinical skills relevant to psychiatry, including:

1. Cultural safety in clinical interviewing.

2. Identifying culturally appropriate community resources for treatment.

3. Developing an integrated treatment plan.

Core Competencies and Essential Skills

Cultural competence involves attitudes, knowledge and skills that enable a mental health professional to provide competent, equitable and effective care to meet the diverse needs of all patients.[96] This requires addressing basic cultural issues, including:

1. The clinician's own identity and relationship to patients from diverse backgrounds.

2. Communication skills and familiarity with how to work with interpreters and culture brokers.

3. Conceptual models of how cultural context and background influence developmental processes, psychopathology, help seeking, coping and adaptation to illness, treatment response, healing, recovery and well-being, as well as moral and ethical issues.

4. Specific knowledge of the particular populations and communities with which the clinician is working.[33,97]

Acquiring cultural competence requires didactic teaching, mentorship and supervised experience in specific clinical and community settings to address each of these domains. At a minimum, this would include:

1. The opportunity to explore and reflect on one's own cultural background and identity as a resource and a source of bias, and to address the interpersonal and institutional dynamics of racism, power disparities, social exclusion and acculturative stress as they impact on mental health and clinical work.

2. Basic knowledge of current research and conceptual models in cultural psychiatry, medical anthropology and cross-cultural psychology relevant for understanding social and cultural influences on the mechanisms of psychopathology as well as cultural variations in symptom expression, help seeking, treatment adherence and response.

3. Training in working with medical interpreters and culture brokers as well as immigrant settlement workers, community workers, counsellors, helpers and healers.[98]

4. Familiarity with the values, perspectives and experiences of local communities pertinent to psychiatric care, including ethnocultural groups, immigrants and refugees across all age groups and life-cycle stages (child, youth, adult and elder).

Table 1 Core cultural competence in the CanMEDS competency framework[a]	
Role	Domain
Medical Expert	
Reflect on and recognize one's own biases and assumptions	A
Understand the epidemiology of mental health problems from a cross-cultural and global perspective	K
Knowledge of cultural differences in idioms of distress, symptom presentation, illness explanatory models and culturally bound syndromes	K
Understand cultural, gender and age-specific theoretical, clinical and therapeutic issues	K
Knowledge of ethnic differences, such as in pharmacokinetics (metabolism), and pharmacodynamics (drug response, susceptibility to side effects), relevant to psychiatric assessment and treatment	K
Ability to negotiate sociocultural factors, such as healer–patient role expectation and power dynamics, which influence the establishment of engagement and therapeutic alliance	S
Conduct and organize an appropriate, culturally competent interview	S
Elicit relevant sociocultural stressors, including the impact of migration, poverty and discrimination, especially in disadvantaged groups	S
Perform an appropriate mental status examination, as shown by a correct and thorough examination of mental phenomena, and the ability to evaluate, organize and interpret observations in the context of sociocultural factors	S
Consider cultural issues and present an integrative biopsychosocial–spiritual understanding	S
Demonstrate the appropriate use of cultural formulation	S
Collaboratively formulate a culturally appropriate intervention plan that takes into account sociocultural factors toward holistic health and recovery	S
Demonstrate an understanding of relevant cultural issues in psychotherapeutic interventions and an ability to adaptively modify the goals, process and content of these interventions	S
Appropriate management of ethnic differences when using pharmacotherapy and somatic therapy	S
Appropriately direct patients to relevant community resources, including relevant ethnocultural-specific services and (or) immigrant and refugee settlement services	KS
Communicator	
Ability to modulate one's communication method and style adaptively to facilitate communication with the patient and their family	AS
Appropriate use of linguistic and cultural interpreters	S
Able to make appropriate use of translated resources for clinical care	S
Ability to effectively negotiate and bridge differences among providers', patients' and families' in their understanding of illness and treatment	S
Scholar	
Awareness of cultural bias and pitfalls in research, including conceptualization, methodology, interpretation and dissemination	AK
Conduct culturally competent research, such as community-based participatory research	S
Professional	
Demonstrate integrity, honesty, compassion and respect for diversity	A
Develop collaborative and respectful patient relationships that demonstrate gender and cultural awareness	AS
Aware of, and the ability to develop, an approach to ethical issues that concern diverse populations	AKS
Collaborator	
Recognize power differences and dynamics in professional collaborative relationships	A
Familiarity with relevant community resources for collaboration	K

Table 1 continued

Role	Domain
Manager	
Demonstrate respect for diversity in working with teams	AS
Aware of power dynamics and take appropriate steps to address inequity owing to sociocultural forces within teams	AS
Participate in and promote quality assurance that takes into account cultural and equity issues	KS
Ensure equitable allocation of health care resources and access to care	AKS
Health Advocate	
Identify and understand the impact of racism, access barriers and other social factors leading to mental health sequelae and health disparities in disadvantaged groups	AK
Knowledge of major regional, national and international advocacy groups in mental health care	K
Ability to engage in effective mental health promotion strategies, including community educational talks and workshops	S
Advocate effectively for the biopsychosocial, cultural and spiritual needs of patients and their families within the health care system and community	S

[a] Adapted from Rotation Specific Educational Objectives, Department of Psychiatry, University of Toronto

A = attitude; K = knowledge; S = skill

Table 2   Core themes in cultural psychiatry curriculum

Number	Core theme	Description	CanMEDS roles
I	Culture and Health	Identify and reflect on the impact of culture and social determinants on healthy development and mental health well-being	Medical Expert, Health Advocate, Scholar and Professional
II	Culture, Illness and Psychopathology	Identify and understand the impact of culture on symptoms, illness experience and psychopathology	Medical Expert and Scholar
III	Culture in Clinical Practice	Address culture in clinical practice to provide cultural competent care to patients and families to facilitate the recovery process	Medical Expert, Communicator, Collaborator, Manager, Health Advocate and Professional
IV	Culture and Health Care Policy, Services and Systems	Identify cultural and equity issues and challenges in policies, service systems and research, and develop strategies to address these gaps through advocacy, empowerment, research and mental health promotion	Medical Expert, Communicator, Collaborator, Manager, Health Advocate and Scholar

5. Experience collecting social and cultural information through individual and family interviewing and assessment and in preparing cultural formulations as outlined in DSM-IV-TR.

6. Experience negotiating treatment with individuals, families and wider community networks relevant to care for patients from diverse backgrounds.

An organizing framework is needed to articulate these training needs as specific competencies. One of the major advances in medical education has been the shift from Flexnerian model of structure and process-based training toward competency-based training.[99] As one of the pioneers in the area of competency-based training, the RCPSC initiated the Canadian Medical Education Directions for Specialists (CanMEDS) project in 1993, which was revised in 2005.[100] The project represents a paradigm shift in the focus of training from the interests and abilities of the providers to the needs of society. The role of specialist physician is expanded from the traditional role of Medical Expert to also include Communicator, Collaborator, Manager, Health Advocate, Scholar and Professional. The CanMEDS framework is particularly relevant for further development as a blueprint for cultural competence training. In Table 1, we link specific core cultural competencies to each of the CanMEDS roles.

Table 3 Learning objectives in a cultural psychiatry core curriculum			
Number	Topic	Objectives and skills	Learning objectives
I Culture and Health			
1	History and culture of psychiatry	Understand mainstream psychiatry, psychology and the mental health field from cultural and historical perspectives	AK
2	History of cultural psychiatry	Understand the ways in which attention to culture in psychiatry is framed by specific historical contexts, including colonialism, migration and globalization	AK
3	Concepts of culture, race and ethnicity, and identity	Define core concepts and apply to analyze relevance and generalizability of research and clinical literature	ASK
4	Ethnopsychologies: cultural concepts of mind, and emotion, self and personhood	Appreciate dominant influence in psychiatry of individualistic concept of person; recognize alternative forms of emotional experience, self and personhood	AK
5	Cultural variations in family, developmental trajectories and definitions of normality; functioning and well-being	Appreciate the diversity of family composition, structure and its roles in defining life stages, goals and values	ASK
6	Social and cultural determinants of health, including impact of migration, colonization, racism and discrimination	Identify major social determinants of health relevant to Canadian context, including experience of indigenous peoples, immigrants, refugees and ethnocultural minorities	AK
7	Cultural sources of resilience and healing, and recovery including religion and spirituality	Recognize role of potential resources for coping, resilience, healing recovery at individual, family and community levels	AK
II Culture, Illness and Psychopathology			
1	Explanatory model of illness and idioms of distress	Distinguish between causal attributions, illness explanations and idioms of distress	KS
2	Culture-bound syndromes	Understand and identify how culture may contribute to discrete syndromes	KS
3	Cross-cultural psychiatric epidemiology; problems of comparability and category fallacy	Understand conceptual and methodological problems, making cross-cultural comparisons, and the cultural variation in prevalence, course and outcome in appraising the literature	KS
4	Help seeking, coping and healing	Understand how cognitive and cultural models influence coping strategies, help seeking and health care use	K
5	Cultural influences on psychopathology in major categories of disorder: mood, somatoform, dissociative, psychotic, substance abuse and personality disorders	Examine in detail the impact of culture on some common and major psychiatric disorders	K
6	Culture change; migration and mental health; acculturation, biculturalism; issues of identity and intergenerational conflict	Identify mental health problems related to culture that are distinct from major psychiatric disorders (for example, V-codes in DSM-IV)	K

Table 3 continued

Number	Topic	Objectives and skills	Learning objectives
III Culture in Clinical Practice			
1	Cultural influences on psychiatric nosology	Recognize the ways that culture, history and politics influence the production and use of psychiatric diagnoses and nosology	AK
2	Models of cultural safety and cultural competence	Identify the core dimensions of cultural safety and cultural competence models designed to improve care	AK
3	Intercultural communication	Understand the impact of cultural difference on clinical communication in medical and psychiatric settings	AKS
4	Working with interpreters, culture brokers, mediators and cultural consultants	Review models and develop basic knowledge and skills needed to work with linguistic interpreters and cultural brokers	KS
5	Cultural formulation	Learn to collect required information and produce a cultural formulation	KS
6	Working with families and communities	Learn models and approaches to family assessment and collaboration with nonfamily cultural resource people	KS
7	Ethnopsychopharmacology	Recognize effects of cultural variations in diet, environment and population genetics on drug effects as well as cultural meanings of medications	KS
8	Culture and psychotherapy	Strategies for adapting psychotherapy (for example, psychodynamic, cognitive-behavioural therapy, and family) to intercultural work; interventions drawn from different cultures (for example, mindfulness)	KS
9	Working with spirituality, religion and healing	Strategies for collaborating with or integrating cultural, spiritual or traditional healing in clinical care	KS
10	Culture and clinical ethics	Identifying and negotiating ethical issues in intercultural mental health care	KS
IV Culture and Health Care Policy, Services and Systems			
1	Models of service for culturally diverse societies	Identify the models of service developed in different countries and jurisdictions, their origins and rationales	K
2	Indigenous mental health	Identify the key issues in the delivery of appropriate mental health services for Aboriginal populations	AKS
3	Immigrant and refugee mental health	Recognize key issues in mental health of immigrants and refugees, including trauma, loss, uncertainty of status, acculturative strategies and stress, and integration	K
4	Mental health promotion	Understand the role of culture in developing and delivering mental health promotion programs	KS
5	Global mental health	Examine the relevance of culture to the delivery of mental health services in low- and middle-income countries	K
6	Culture and human rights	Recognize the status of culture as a human right and its impact on mental health services and other human rights issues	AK
7	Advocacy and quality assurance	Strategies for managing system change and advocacy to ensure equity in mental health care and outcomes	KS
A = attitude; K = knowledge; S = skill			

To facilitate the design of a cultural competence curriculum to fulfill the specified CanMEDS competencies, major organizing themes from the field of cultural psychiatry can be identified as basic teaching modules: Culture and Health; Culture, Illness and Psychopathology; Culture in Clinical Practice; and Culture and Health Care Policy, Services and Systems (Table 2). A model curriculum with specific learning objectives outlined for each of the four teaching modules is summarized in Table 3.

Community-based groups, institutions and organizations are an important source of knowledge and resources. They can offer support, guidance and information on the needs, illness models and histories of local groups' exposure to risk factors. Community organizations may offer services that are more culturally consonant but also that may be a source of stigma or a barrier to accessing mental health services. Developing working relationships with community-based organizations is an important skill for working in a diverse setting.

The reorganization of mental health services around shared care models calls for a shift in the role of psychiatrists, who need to develop specific skills to become effective consultants for primary care professionals. This includes:

1. Understanding the inter-institutional and systemic dynamics that influence partnership, referral, follow-up and joint care of patients.

2. The capacity to conduct an ecological appraisal of individual, family and community resources and to translate this into a multi-sectorial intervention plan.

3. Flexibility in shifting between different aspects of the consultant role while preserving a clear focus on the clinical goals.

Pedagogical Methods

Cultural psychiatry involves pragmatic and political issues of equity in health services as well as fundamental scientific questions about the nature of psychopathology. Therefore, training needs to balance experiential learning that focuses on attitudes and enhances skills, with didactic and conceptual teaching that emphasizes models, methods and data.[26] Training can employ various pedagogical methods, including:

1. Individual or group reflective exercises and assignments in a safe environment, which may best facilitate personal shifts in attitudes.

2. Prescribed readings, didactic presentations, and case studies, which can increase trainees' knowledge in key concepts and issues of providing care for diverse populations.

3. Role-playing, observed interviews, direct patient care, and family and community interventions and collaborations, which are all invaluable learning opportunities for skill acquisition, through modelling, feedback and supervision.[26]

These approaches overlap and reinforce one another. For instance, direct experience in working with a particular patient population not only improves clinical skills but also leads to increased working knowledge and attitudinal shifts, especially if facilitated by appropriate supervision. The self-reflective and didactic learning activities can be delivered through cultural competence seminars, case conferences and rounds, while the acquisition of clinical skills is most effective if integrated into rotations throughout the entire residency. This integrative approach is particularly important to make it clear that cultural competence is a core competence needed in every clinical encounter for every psychiatrist.[33]

Training in cultural psychiatry requires creating settings that encourage a self-reflective process in which trainees become aware of their own cultural and sociopolitical premises and assumptions, which may be grounded in their identity and personal history but also may arise from aspects of collective experience of which trainees are unaware. For example, histories of colonization have shaped the identity of many peoples and the resultant attitudes toward authority and emblems of dominant and subordinate groups will influence attitudes and behaviour in the clinical setting.

Understanding and respecting the cultural background of the other involves attitudes of interest, as well as modesty or humility.[101] The intercultural clinical encounter is a mirror of similar encounters in the larger society and brings with it all of the cultural and historical assumptions, tensions and expectations that frame such everyday interactions. Clinicians must learn to use their own identity, both in terms of self-understanding and—with an awareness of how they appear to others, given this social historical background—as a tool to explore their patients' identity, illness meanings, the social context of illness and adaptation, and the clinical relationship itself.[102] This self-awareness is the focus of experiential learning and clinical training.

Capitalizing on the diversity of backgrounds among trainees and professionals themselves can provide an excellent way to foster positive attitudes and encourage more empathic understanding of the realities of immigrant and minority experiences. This requires training and practice environments in which it is safe for clinicians to reflect on and discuss cultural issues. The development of a discussion and reflection group for trainees insulated from the formal evaluation processes of training can facilitate a more open, personal exchange.

In addition to understanding how their own backgrounds influence the clinical interaction with others, trainees need to consider the ways in which the concepts and practices of psychiatry are based on specific cultural constructs and values. For example, the emphasis on autonomy and individual choice as markers of psychological health and as therapeutic goals reflects the dominant values of individualism. These are challenged by traditions that place a higher value on family or group harmony and consensus. Thus the clinical setting can be seen as a space of negotiation between different cultural systems of knowledge and practice and different value systems that reflect the implicit values and ideologies that structure medical knowledge and the health care system.[103–105] Medical and psychological anthropology provide conceptual frameworks and comparative studies of health care systems that can inform clinical work in cultural psychiatry. Among existing models in psychiatry and allied mental health disciplines, the perspectives of family systems theory and family therapy are most readily adapted to understanding the particularity of migrant individuals and ethnocultural communities. The emphasis on systems, or networks of relationships, fits well with the values of people from many backgrounds.

Awareness of differences in cultural knowledge, values and orientations provides a foundation for learning the essential skills of cultural psychiatry: establishing a working alliance in the context of power imbalances, divergent values and differing views of the world; formulating problems in terms of specific social and cultural dynamics; and developing treatment plans that mobilize available resources, and negotiating interventions with patients, their families and communities.

Intercultural work also requires tolerance for ambiguity. This poses a challenge for models of professional practice that emphasize mastery and efficiency. There must be space for clinicians to acknowledge the uncertainty in assessment and treatment, and time to clarify assessment and negotiate appropriate interventions. In training, this requires a supportive environment. In health care institutions, it requires structural changes to allow for the additional time and resources needed to provide adequate care.

Ultimately, the wide implementation of culturally safe and competent practices depends on institutional changes. Clinicians may be key actors in initiating and promoting such change. Problem solving with trainees around the construction of a support network (at the level of clinical team and institution) can support the shift in clinical practices from a model centred on professional expertise to one that is more patient-centred and that can deal with uncertainty.

Additional pedagogical methods useful for cultural psychiatry training include:

Case Studies

Clinical team meetings and other settings where individual cases are discussed provide a key method for learning the process and content of cultural formulation. The case study method, which is standard in medicine, can be used to analyze the complexity of cultural influences on patient presentation and evolution, identify cultural dimensions of clinicians' positions and work on biases and unexamined premises.

Education in Pluralism

Cultural psychiatry rests on a basic respect for diversity in world views. This diversity includes notions of knowledge, authority and values that may be radically different from those of the practitioner. Working with such radical differences requires some understanding of philosophical and ethical notions of pluralism as well as skills in dialogical encounter that can be modelled and practiced in workshop settings with trainees and reinforced through clinical supervision.

Experience With Inter-Institutional and Inter-Sectorial Community Work

Trainees need experience consulting on institutional and community issues. Addressing systemic issues can be taught through in-service seminars that bring together participants from multiple sectors and institutions for in-depth case discussions.[106,107]

Fostering Ethical Reflection

The predicaments of refugees, ethnocultural minorities and other vulnerable populations or marginalized groups raise complex ethical issues, involving situations where professionals must consider modifying standard procedures and adopting positions of advocacy without appropriating the voice or experience of the other.[108] Training requires a setting where ethical issues can be made explicit and discussed from multiple perspectives.

With appropriate supervision, any clinical setting with a high diversity in the patient population can be useful for training in cultural psychiatry. In addition, certain types of specialized programs, including cultural consultation and ethno-specific services, can provide opportunities for more advanced training.[109,110] This may involve specialized inpatient, outpatient and community consultations, and time-limited treatment.[111,112] These rotations usually involve clinical activities that include direct patient contact, consultation with referring clinicians and outreach to community referral sources. Because it emphasizes consultation with other professionals, a cultural consultation rotation is most appropriate for senior trainees. Much learning takes place from focused reading around cases and working closely with culture brokers. Group supervision and the self-disclosure of experienced clinician-mentors are crucial to developing clinical skills and confidence, and an effective clinical approach.

Research Training

There is a need for more research on all aspects of the interplay of culture and mental health, including models of psychopathology, health services and recovery. To address issues of cultural diversity in mental health services, researchers require familiarity with a broad range of methodologies.[37] Research with Aboriginal populations raises particular ethical issues. Of particular importance for cultural psychiatry are community-based participatory research methods that engage communities in all aspects of research, including design, recruitment, implementation, data-gathering, interpretation and dissemination. Teaching research skills in cultural psychiatry requires a balance between methodological rigour and learning to question one's own discipline through other perspectives.

Assessment in Training and Continuing Professional Development

Assessment is an essential component to cultural competence training in residency, as it provides not only a summative evaluation of the trainee but also formative feedback that facilitates learning and a motivational incentive to continuously reflect, learn and make behavioural changes. The concept of blueprinting—borrowed by educational scholars from the field of architecture—can be useful to map out in advance test construction against learning objectives (such as combining CanMEDS roles and the attitudes–skills–knowledge [ASK] model of cultural competence) with the objective of creating valid evaluation tools.[33]

Attitudes can be assessed through reflective journalling and essays, as well as through clinical supervision and direct observation. Content-based knowledge, especially from seminars, workshops and case conferences, can be assessed efficiently through written multiple-choice or short-answer examinations. Skills can be assessed through Objective Structured Clinical Examinations (commonly referred to as OSCEs), observed or recorded interviews, direct supervision of care and chart reviews. Some examples of formative assessment tools that have been developed include the addition of cultural stems and statements for RCPSC-style oral examination score sheets, including thorough mention of cultural identity, need for interpreters, inquiry into explanatory models and awareness of areas where cultural factors may be present in the mental status examination, in addition to mention of culture where appropriate in the diagnosis and treatment plan. In Table 4, we present a sample template for evaluating specific cultural competency components of observed interview and case presentation. These components can be adapted and integrated with existing scoring

Table 4 Evaluation template for observed interviews and case presentation[a]	
1.0	Physician–Patient relationship • Engages the patient in a culturally appropriate manner
2.0	Interview and MSE • Appropriately adapts the interview and MSE to be cultural competent Interview Content • Identifies social and cultural stressors and systemic inequities • Explores the patient's explanatory model of illness • Reviews complementary and alternative treatments • Reviews relevant cultural identities, migration history–trauma–stress, acculturative strategies and spirituality • Identifies social and cultural supports, including family, kin networks and communities
3.0	Case presentation • Accurately presents relevant social and cultural issues and their impact on presentation and diagnosis
4.0	Formulation • Accurately identifies social and cultural components of the patient's illness
5.0	Treatment plan • Identifies further biopsychosocial–cultural investigations immediately required to consolidate the diagnosis or provide optimal care of the patient • Able to consider social and cultural factors in all aspects of treatment planning • Able to recommend and defend appropriate collaborations with family, community or other service providers • Able to address issues that may impact recovery beyond symptom reduction

[a] Adapted from the Department of Psychiatry, University of Toronto Oral Examination Scoresheet

MSE = mental status examination

sheets, and can be used for formative feedback in regular practice interviews as well as final evaluative examinations.

Annual in-training evaluation reports are important opportunities to review the overall core cultural competencies under each of the CanMEDS roles, identify areas to improve on, and facilitate a learning plan. There is an emerging trend to employ multi-source (360-degree) feedback as an evaluation methodology, and this is particularly relevant in assessing core cultural competence of working with the diverse communities as a Medical Expert, Collaborator and Manager. Depending on the rotations, the multi-source feedback

should include considerations of input from supervisors, interdisciplinary health professionals, relevant community partners and, if possible, patients and their families.

Faculty development is critical to the success of the cultural competence training.[113] Providing continuing professional development (CPD) programs to existing faculty is important to enhance awareness of content and concepts within the expanded residency curriculum and to improve supervisory and evaluation skills. Faculty themselves should be evaluated on their own cultural skills in clinical work and supervision. Cultural competence can be added as a heading on supervisor evaluation forms, where psychiatry residents can similarly rate their staff on inclusion and awareness of cultural issues during supervision on all mandatory clinical rotations as well as on electives. Cultural competence can also be assessed at the level of health care systems and institutions.[114] Organizational change is an essential complement to efforts directed toward practitioners.

Building Infrastructure to Implement Training

Implementing training in cultural psychiatry requires development of local infrastructure. However, most communities will have many of the key resources that can be brought together to support training. Three key ideas can guide this process:

1. The leadership should be diverse, including faculty, residents and community members. Developing a common understanding among the leadership through facilitated workshops focused on producing a local curriculum and an implementation plan can help to catalyze the process.

2. Resources needed for the plan are mainly the time of trainees, faculty and community educators. Supervisors must be conversant with approaches to cultural safety and cultural competence, or engage other professionals and community members with expertise to provide support to trainees in this area. Exposure to the work of community groups and training or placements in settings that offer culturally specific care can be helpful with appropriate supervision.

3. The introduction and refinement of a new curriculum requires ongoing evaluation. Therefore, part of implementation is the development of a process to monitor the curriculum, obtain feedback and identify ways that training can be improved. Accreditation and other methods of local monitoring can insure that this information is used to improve training.

Conclusion

Globalization is increasing the importance of cultural psychiatry as an academic discipline and a central pillar of clinical training and service delivery. Recognition that culture is central to identity and well-being, and that certain groups suffer from marked inequities in mental health and access to services, has spurred systematic attention to culture in psychiatry.

The Section on Transcultural Psychiatry of the CPA is developing a knowledge exchange centre to share curriculum materials, interactional learning and self-assessment tools, as well as models of clinical practice and organizational change. Through new initiatives within training programs and CPD, cultural psychiatry can become a core aspect of the knowledge and skills of all psychiatrists. These professional competencies need to be coupled with institutional changes, monitored by accreditation bodies, to ensure that all Canadians benefit from a culturally safe and competent mental health care system that can respond to the needs of our diverse population in a respectful and effective way.

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