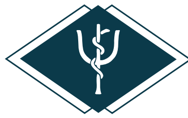

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POSITION PAPER

Guidelines for Training in Cultural Psychiatry

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Introduction

Canada is a highly diverse society and, through policies of multiculturalism and a vigorous academic and research tradition of transcultural psychiatry, Canadian scholars and clinicians have been world leaders in efforts to understand the impact of culture on mental health. In response to the need for national guidelines for the integration of culture in psychiatric education and practice, an earlier version of this position paper was prepared by the Section of Transcultural Psychiatry of the Canadian Psychiatric Association (CPA) for the Standing Committee on Education. This revision updates the paper

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with new material reflecting advances in psychiatric education and cultural psychiatry, including competence-oriented training methods, recent research on cultural and social structural determinants of mental health and the introduction of cultural formulation interview (CFI) in *DSM-5*. The guidelines are 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, racialized and ethnocultural groups, as well as First Nations, Inuit and Métis.

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 like depression, anxiety and trauma-related problems as well as psychoses and organic mental disorders.[2,3] 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.[4-9] Inequity does not arise from cultural diversity per se but from the responses of health and social systems to diversity. Any mental health care system that aims to achieve equity must therefore address issues of cultural diversity.[10] This has been recognized by governmental and professional organizations in the United States, United Kingdom and other countries as well as Canada.[4,11,12]

The Mental Health Commission of Canada, in its framework for a mental health strategy, included addressing the diverse needs of Canadians as the fourth of seven basic principles of a reformed mental health care system.[13] 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 to influence crucial social determinants of health, access to care, quality of services and outcomes.[14,15]

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.[16-20] The Canadian context is distinctive in many ways. Since 1976, Canada has had an official policy of multiculturalism.[21] This formally acknowledges and promotes recognition of the diversity of Canadian society as a shared feature of collective identity.[22] It reflects and contributes to a social milieu in which attention to culture is positively valued and, indeed, required in order 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.[23-26] Recent years have seen greater recognition of the history of colonization and the devastating impact of the policies of forced assimilation on Indigenous 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. The final report of the Truth and Reconciliation Commission outlined measures to promote reconciliation, including specific changes to the health care system to ensure cultural safety.[27,28]

Although Canada has been a culturally diverse nation from its inception, the geographic origin of newcomers to Canada has changed. Before 1960, over 90 per cent of immigrants were from Europe; by 2006, this had dropped below 19 per cent. At present, the majority 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, United Kingdom and Australia to develop training guidelines and materials to enhance clinicians' cultural competence.[29-31] 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 cultural or linguistic dimensions of health care access or delivery.[32] Recent efforts to address health disparities have argued for the importance of structural competency in medical training and practice.[33]

Models of training in the United States have been organized in terms of the five ethnoracial blocs defined by the U.S. census (African American, Asian American and Pacific Islanders, Hispanic, American Indian and Alaskan Native and White).[17] This clustering of diverse groups into major blocs facilitated advocacy efforts of minority groups in the United States.[34] While this fosters a basic level of recognition of diversity, it downplays the heterogeneity and diversity of groups. Training 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 Indigenous peoples and refugees.[35] 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.[36,37]

Surveys of training in cultural psychiatry in Canada have revealed uneven development across the country.[38] The majority of Canadian psychiatric residency programs offer limited exposure to cultural psychiatry.[39] This reflects the fact that regulatory bodies and organizations in Canada have not developed specific guidelines for training or clinical practice in cultural psychiatry. The only mention of cultural issues in the Royal College of Physicians and Surgeons of Canada (RCPSC) accreditation standards states: "Learning environments must include experiences that facilitate the acquisition of knowledge, skills and attitudes relating to aspects of age, gender, culture and ethnicity appropriate to psychiatry (p. 9)."[40] There is also mention that there must be facilities for supervised experience in community consultations. There is no mention of other specific topics or populations including immigrants, refugees, ethnocultural communities, or the use of interpreters. A CPA position paper on training for work in rural and remote areas makes brief mention of the importance of attention to local culture and of Indigenous mental health issues.[41] Earlier position papers on training in emergency psychiatry and substance abuse both acknowledge the relevance of sociocultural factors; however, no detail on curriculum is provided.[42,43]

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.[44-49] 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.[50] 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 bodies of technical or professional knowledge and practice like psychiatry are also imbued with culture. Cultures also produce forms of social identity, including racial categories and ethnicity, which may be ascribed to individuals. The process of racialization categorizes people on the basis of their appearance or some other characteristic.[51-53] Although there is no coherent biological definition of race, *racialization* is important because of racism, which has been shown to have direct impacts on physical and mental health but also through the fundamental impacts that racism has on exposure to social determinants of health. Institutional racism, discrimination, social exclusion and oppression also can influence the way that groups perceive and interact with health services.[54] *Ethnicity* refers to the ways in which groups identity themselves as historical peoples or communities.[55] The dynamics of culture, race and ethnicity are not simply intrinsic to a group but depend on interactions among groups within a larger society. Canada has its own unique history and dynamics relevant to identity and mental health.[56]

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*[57] that reflect culturally mediated differences in human populations, based on diet, ways of life and coevolution with selection for specific genetic polymorphisms.[58,59] These variations may contribute to behavioural differences across populations as well as to pharmacokinetic and pharmacodynamic differences in medication response.[60] Brain development depends crucially on the social environment, which is shaped by cultural practices.[61,62] A growing body of work in cultural neuroscience reveals ways in which differences in child-

rearing and everyday social contexts influence neuropsychological mechanisms of attention, memory, cognition and emotion, self-representation and psychopathology.[63-65]

Social and Cultural Determinants of Health and Health Disparities

Cultural differences result in particular social statuses, identities and positions, which are associated with varying exposure to particular types of social determinants, adversity and access to resources, including health services. This results in substantial disparities in the prevalence of specific mental health problems and health outcomes. Local cultural values, practices and institutions interact with larger social determinants of health including globalization, migration and urbanization. Complex interactions between vulnerability, individual and community resilience, and the social determinants of health, influence the risk of specific mental health problems for different groups. As a result, there are significant differences in the rates of mental health problems between groups in Canada.[66] For example, in Ontario, the rates of psychosis are 60 per cent higher for Caribbean immigrants than they are for Canadian born or African immigrants; however, the rates of psychosis among those from the Philippines are 50 per cent lower.[67] Refugee populations tend to be at increased risk of both common mental disorders and psychosis, but the risk of illness is influenced as much by postmigration issues as it is by premigration factors such as exposure to violence.[68] A nuanced approach to understanding and considering these influences in assessment, treatment and research is most likely to produce better outcomes.[69]

Racism, Prejudice and Discrimination

Among the most important social determinants of health are systematic exposure to discrimination and exclusion which may be associated with explicitly racist ideologies or with more implicit forms of bias and discrimination both at the level of individuals' behaviour and as part of routinized institutional practices.[54,70,71] These forms of discrimination result in structural inequalities as well as in everyday practices of stereotyping, misrecognition, denigration and "microaggression" that may have negative effects on mental health and service delivery.[72]

Institutional Racism

Institutional racism, defined as institutional failures to provide appropriate care and services because of culture, ethnic origin or race, 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 which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and stereotyping that can disadvantage minority groups.[73,74]

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.[75] A literature on postcolonial psychology examines the social, political and mental health consequences of these histories for contemporary populations, including Indigenous peoples and many immigrant groups.[76,77]

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.[78,79] Examples include the diverse types of panic disorder that depend on culture-specific interpretations of sensations[80] and the variations in the form and prevalence of dissociative disorders reflecting the use of dissociation in religious and healing traditions.[81]

Illness and Help-Seeking Behaviours

Cultural understandings of the nature of sensations, symptoms, illnesses and other types of problems guide coping, help-seeking and health care utilization. Independently 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

A variety of 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. 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.[82-84] In addition to cultural competence, the Mental Health Commission of Canada has 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.[85-87] 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

DSM-5 includes a cultural formulation interview (CFI) and Outline for Cultural Formation (OCF) for collecting and organizing clinically relevant cultural information into a diagnostic formulation.[88] The CFI is presented both in patient and key informant versions and 12 supplementary modules are available to assess specific domains (explanatory models, level of functioning, social networks, psychosocial stressors, spirituality, religion and moral traditions, cultural identity, coping and help-seeking, and the patient–clinician relationship) and issues related to specific populations (children, elders, migrants, caregivers) as well as detailed guidelines for conducting CFIs with patients and their families.[89] *DSM-5* also introduced important constructs for assessing cultural concepts of distress including cultural explanations, idioms of distress, cultural syndromes and folk diagnoses.[90]

Working with Interpreters and Culture Brokers

Over 20 per cent of the Canadian population has a mother tongue which 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.[91] Practical constraints and professional attitudes contribute to a reluctance to use interpreters.[92] As a result, trained interpreters continue to be underutilized 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 in order to address the challenge of assessing development across cultures as well as intergenerational conflict within immigrant families.[93]

Information and Communication Technologies and Social Media

The rapid development of information and communication technologies and social media have had substantial impact on many facets of mental health and service delivery and will become increasingly important in the years to come. There are at least four ways in which these technologies must be considered in training in cultural psychiatry, related to their impact on (1) individual development, identity and well-being; (2) changing social networks and communities (e.g., diasporic and transnational communities, groups formed around common interests or concerns including illness); (3) new forms of psychopathology (e.g., problematic Internet, cellphone or video game use) and (4) the delivery of mental health information and interventions.[94-96] All of these domains interact with specific social factors and require expanding our notions of culture and context and addressing diversity to ensure equitable access and effectiveness.

Computational Psychiatry

Efforts to use bioinformatics and artificial intelligence to develop methods for more precise clinical assessment and targeted treatment must take into account social and cultural diversity. Current diagnostic and treatment algorithms generally pay little attention to diversity, and clinicians need to be trained in how to apply these tools in ways that integrate culture and context in a developmental and ecosocial frame.[97,98]

Policy Issues

The design and implementation of culturally safe and competent mental health care systems and institutions requires attention to structural and organizational issues at multiple levels.[99] 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.[100,101]

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. Cultural issues are central in efforts to export and adapt interventions. Respect for culture, as essential to human identity and well-being, is also a 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.

Indigenous Mental Health

Indigenous peoples constitute about four per cent of the Canadian population but bear a disproportionate burden of mental health problems.[102,103] 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.[104-107] The Indian Act, the Indian Residential School system and the child welfare system have had profound effects on the mental health of Indigenous populations.[108-110] These historical events have resulted in what has been termed “intergenerational trauma.” In response, Indigenous individuals and communities have developed unique resources and strategies of resilience reflecting culture, language, spirituality, and connections to family, community and place to mitigate the effects of intergenerational trauma and ongoing structural violence.[111]

There is wide recognition of the need for training in cultural safety and competence to respond to the mental health needs of Indigenous peoples.[112,113] 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 Indigenous peoples in Canada live in cities where they may not have access to culturally appropriate services that respect and make use of their language, cultural and spiritual traditions. Indigenous organizations have 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.[114-116] Cultural safety focuses on addressing the structural inequalities and power imbalances that make clinical encounters unsafe for Indigenous people.[87,117,118]

The Indigenous Physicians Association of Canada and the RCPSC have developed core curriculum and clinical interviewing training materials for residents.[119,120] Training involves reading, discussion, role-playing and interaction with trainers from Indigenous communities to provide (1) 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 and (3) developing an integrated treatment plan. Recent publications provide guidance on training in cultural safety and Indigenous mental health issues.[121,122]

Core Competencies and Essential Skills

Cultural competence requires changes at the levels of systems, practitioners and interventions.[31,36] At the level of practitioners, cultural competence 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.[123] 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.[44,124] Practitioners also need to understand the importance of cultural adaptation of care pathways and interventions as well as how to advocate at the system level for equitable systems and indicators that allow the measurement of progress toward equity of access and outcome.

At the centre of cultural competence are relational skills and processes to build trust, mutual understanding

and collaboration, integrated with understanding the phenomenology and situated meaning of symptoms and illness experience.[125-127] Acquiring cultural competence requires didactic teaching, mentorship and supervised experience in appropriate 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, counselors, helpers and healer.[128]
4. Familiarity with the values, perspectives and experiences of local communities pertinent to psychiatric care, including ethnocultural and racialized groups, immigrants, and refugees across all age groups and life cycle stages (child, youth, adult and elderly),
5. Experience collecting social and cultural information through individual and family interviewing and assessment and in preparing cultural formulations using the CFI and OCF in *DSM-5* or comparable tools.
6. Experience negotiating treatment with individuals, families and wider community networks relevant to care for patients from diverse backgrounds.

Each of these areas involves didactic teaching, clinical experiences, and the creation of specific learning and practice settings to allow ongoing discussion, reflection, and integration of attitudes, knowledge and skills.

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.[129] The RCPSC initiated the Canadian Medical Education Directions for Specialists (CanMEDS) project in 1993, with revisions in 2005 and 2015.[130] CanMEDS shifted the focus of training from the interests and abilities of the providers to the needs of society. In addition to the traditional role of medical expert, the specialist physician's roles include communicator, collaborator, leader, health advocate, scholar, and professional. The CanMEDS framework is particularly relevant for further development as a blueprint for cultural competence training. In the most recent update, cultural safety has been explicitly highlighted in the communicator role.[130] In Table 1, we link specific core cultural competencies to each of the CanMEDS roles and the corresponding enabling competencies.

In addition to capturing competencies as roles, the RCPSC is committed to a shift toward competency by design (CBD) for all postgraduate training. This differs from traditional medical training by shifting from a time-based, rotation-centred, knowledge acquisition curriculum toward a more learner-driven approach, with progress in training marked by attaining observable skills through frequent formative as well as summative assessments.[131] Pragmatically, most postgraduate programs will likely adopt a hybrid format retaining some form of clinical rotation structure with increased flexibility.

The CanMEDS Milestones outline the skills to be attained under each role at each stage of training.[132] The stages of training are divided into (1) *transition to discipline*, which may take the form of a "boot camp" ensuring that medical graduates from different medical schools inside and outside Canada are ready to begin residency training with standard basic skills (also see CPA position paper on IMG training); (2) *foundations of discipline*, junior residents foundational training; (3) *core of discipline*, senior residents training covering the majority of core competencies; and (4) *transition to practice*, senior residents training after the Royal College Examination in preparation for the transition to independent practice. In Table 1, we have developed draft milestones for the core cultural competencies to guide curriculum design, implementation and evaluation.

Another concept in CBD is the entrusted professional activities (EPAs), which describes observable clinical tasks that supervisors may entrust trainees to perform under varying degrees of supervision depending on their level of competence. Each delineated EPA integrates relevant enabling competencies from the different CanMEDS roles. For example, the clinical task of providing care to a refugee naturally encompasses competencies associated with medical expert, communicator, collaborator, professional and health advocate roles. While the use of EPAs and milestones vary, in Canada the current direction is toward the use of

Table 1. Core Cultural Competencies and Milestones in the CanMEDS Framework[a]

Role	Domain[b]	CanMEDS Enabling Competencies[c]	Transition to Discipline	Foundations of Discipline	Core of Discipline	Transition to Practice	Advanced Practice
Medical expert							
Reflect on and recognize one's own biases, privilege and oppression, appreciating intersectionality.	AS	1.2, 1.6	Describe how biases and assumptions impact on clinical care. Define concepts related to power, privilege and oppression.	Identify how these concepts are reflected in the clinical relationship and use an anti-oppressive framework to formulate and deliver care to patients.	Identify institutional oppression and reflect on how it can be perpetuated and alleviated in mental health care.	Incorporate evolving knowledge into one's practice and adapt to the changing sociopolitical and cultural landscape.	Teach and facilitate reflection skills among health providers in a way that does not provoke defensiveness.
Develop and maintain an awareness of the impact of racialized identity in assessment and diagnosis that may result from bias and sociocultural factors affecting presentation.	AK	1.3, 1.6, 5.1	Describe the impact of racialized identity in the assessment of patient presentations and diagnoses (e.g., psychoses). Describe the impact of racism in the lives of clients.	Identify ways in which cultural idioms of distress, clinician biases and quality of the therapeutic relationship contribute to differences in assessment and diagnoses.	Identify ways in which personal biases influence interpretations of distress and the quality of the therapeutic relationship, leading to differences in assessment and diagnoses.	Minimize impact of personal biases by using structured assessment tools/ instruments, maintaining awareness of and appreciation for differences in expression of symptomatology, and the impact of systemic/ individual racism in development of trust in therapeutic relationship.	
Identify spectrums of gender and sexual orientation and appreciate the impact of sexism, homophobia and transphobia on individual and community mental health; create safe inclusive space with respect to gender and sexual orientation.	KS	1.3, 5.1, 5.2	Define basic concepts and terms, including sex/gender, gender identity, gender expression, sexual orientation. Identify systemic discrimination and individual/ community trauma due to gender/sexual orientation and how these interact with psychiatric illness.	Apply concepts to work with individuals (e.g., asking for preferred pronouns routinely, assessing for gender-based violence).	Integrate current understanding of gender identity to provide support and counselling on gender dysphoria.	Create a clinical space that is respectful and inclusive of various genders and sexual orientation.	
Undertake necessary learning to understand colonization of the Indigenous peoples of Canada and contribute toward cultural safety and healing.	KS	1.3, 5.1, 5.2	Describe the history of the colonization of Indigenous people; define transgenerational trauma.	Apply concepts to work with Indigenous individuals.	Identify historical and systemic problems related to child protection services, criminal justice system and health care for Indigenous peoples.	Create a safe space clinically and among treatment teams that is respectful and inclusive of Indigenous peoples.	Foster collaboration with Indigenous groups.
Identify marginalized groups and contribute to cultural safety and empowerment.	KS	1.3, 5.1, 5.2	Describe psychiatry's history with marginalized populations, understand Indigenous concepts of the person, wellness, and resilience	Understand how the DSM can potentially contribute to "othering" and oppression.		Create a clinical space that abides by an anti-oppression framework.	
Apply knowledge on the epidemiology of mental health problems from a cross-cultural and global perspective.	KS	1.3			Consider the epidemiology of mental health problems from a cross-cultural and global perspective and their impact on diagnosis and care.		Advance the research on epidemiology of mental health problems globally.

(continued)

Table 1. (continued)

Role	Domain[b]	CanMEDS Enabling Competencies[c]	Transition to Discipline	Foundations of Discipline	Core of Discipline	Transition to Practice	Advanced Practice
Identify and work with cultural concepts of distress, including cultural syndromes, cultural idioms of distress and explanatory models.	KS	1.3, 2.1, 2.2	Describe the role of cultural concepts of distress and give common examples	Identify and work with cultural concepts of distress in clinical care.	Identify and work with cultural concepts of distress among patients and families.		Conduct research to further elucidate different cultural concepts of distress.
Identify and work with sociocultural factors, including stressors, supports and resilience, taking into account intersections of age, socioeconomic status, gender, sexual orientation, religion, spirituality, migration and cultural identities. Use structural competency framework as appropriate.	KS	1.3, 2.2	Identify sociocultural issues and their impact on care.	Identify and work with sociocultural stressors, supports and resilience in clinical care.	Identify and work with sociocultural stressors, supports and resilience with patients, families, or communities.		Conduct nonexploitative and collaborative research on sociocultural stressors, supports and resilience.
Identify and work with ethnic differences relevant to pharmacological and somatic treatment, such as differences in pharmacokinetics (metabolism), pharmacodynamics (drug response) and susceptibility to side effects.	KS	1.3, 3.1, 3.4		Identify and work with ethnic differences relevant to management.			Conduct research on ethnic differences in treatment.
Negotiate sociocultural factors, such as healer–patient role expectations and power dynamics, which influence the establishment of culturally safe and competent clinical engagement and therapeutic alliance.	AS	1.2, 1.6	Identify sociocultural factors in establishing culturally safe engagement and therapeutic alliance.	Negotiate sociocultural factors in establishing culturally safe engagement and therapeutic alliance in care.	Negotiate sociocultural factors in establishing culturally safe engagement and therapeutic alliance with patients and families individually and in care teams.		
Conduct and organize an appropriate, culturally competent and safe interview including 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, utilizing the cultural formulation interview (CFI) as appropriate.	S	2.2		Conduct cultural competent and safe interviews.	Conduct cultural competent and safe interviews, including the appropriate and correct use of the CFI.	Demonstrate the use of appropriate supplementary modules of CFI.	
Formulate an integrative cultural understanding using the bio-psycho-social-spiritual framework (culture embedded in the BPSS framework) and the outline of cultural formulation (OCF).	S	2.2, 2.3, 2.4		Formulate cultural issues using the BPSS framework.	Formulate cultural issues using the BPSS framework and the OCF.		

(continued)

Table 1. (continued)

Role	Domain[b]	CanMEDS Enabling Competencies[c]	Transition to Discipline	Foundations of Discipline	Core of Discipline	Transition to Practice	Advanced Practice
Collaboratively formulate a culturally appropriate intervention and management plan taking into account sociocultural factors toward holistic health and recovery.	S	2.3, 2.4		Collaboratively formulate a culturally competent and safe management plan in patient care.	Collaboratively formulate a culturally competent and safe management plan in individual- and team-based care, including with community partners and healers.		
Culturally adapt psychological and social interventions as appropriate, including modifying the goals, process and content.	S	3.1, 3.4		Culturally adapt psychological and social interventions as appropriate in clinical care.		Apply culturally adapted psychological and social interventions as appropriate for specific communities or populations.	Develop and research cultural adaptation of psychological and social interventions for specific communities or populations.
Facilitate patient and family access to relevant community resources, including mainstream, cross-sector, and/or culturally specific services (e.g., immigrant and refugee settlement services, LGBTQ+ agencies, faith organizations, nongovernmental organizations, consumer organizations, aboriginal services).	KS	3.3, 4.1	Identify relevant community resources for diverse communities.	Facilitate patient and family access to relevant community resources in care.			Facilitate structural changes to improve access to relevant community resources.
Communicator							
Modulate one's communication method and style adaptively to facilitate communication with the patient, family and the communities.	AS	1.1 to 1.6, 2.1		Identify patient's communication style (verbal, nonverbal, high vs. low context) and adapt accordingly.	Identify patient's and family's communication styles, including dynamics and challenges, and adapt accordingly.		Identify patient's, family's, and community's communication style and adapt accordingly, including community work.
Demonstrate appropriate use of translated materials and linguistic and cultural interpreters, identifying the process of meaning-making, supporting empowerment and resilience, with attention to the impact on recovery.	S	1 to 4	Identify and utilize translated materials for care.	Effectively work with interpreters to address language barriers.	Effectively work with linguistic and cultural interpreters to address language barriers and explore cultural factors.		Train linguistic and cultural interpreters.
Effectively negotiate and bridge differences in provider's, patient's and family's understanding of illness and treatment.	S	2.1, 2.3, 3, 4		Elicit and consider patient's explanatory model of illness/treatment.	Elicit and negotiate among patient's, family's and provider's explanatory model of illness/treatment.		Elicit and negotiate among patient's, family's community stakeholders', and health provider's explanatory model of illness/treatment.
Scholar							
Engage in continuous learning to enhance cultural competence (CC) and safety.	AKS	1.1 to 1.3	Reflect on own sociocultural biases on their impact on care.	Develop an approach towards clinical CC (micro) and safety.	Develop an approach towards systemic CC (meso/macro) and safety.	Develop specific CC for specific populations.	Develop and conduct research on CC and safety, including first-person narratives.

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Table 1. (continued)

Role	Domain[b]	CanMEDS Enabling Competencies[c]	Transition to Discipline	Foundations of Discipline	Core of Discipline	Transition to Practice	Advanced Practice
Role model, teach and promote cultural competence and safety among health care providers.	S	2.1 to 2.6			Promote cultural competence and safety among health care providers.		Role model, teach and promote cultural competence and safety among health care providers.
Identify biases and limitations in evidence-base influenced by cultural factors, political forces and history in the construction of knowledge and framing in research, from conceptualization to methodology, interpretation and dissemination. Appreciate and consider other models of knowledge generation.	AKS	3.3, 3.4, 4.1 to 4.4	Identify how current forms of knowledge are generated in psychiatry.	Recognize the limitations/ cultural biases of evidence-based medicine.	Develop safe and culturally adapted uses of the research to reconcile the differences.	Facilitate dissemination of knowledge and gaps from a critical perspective to health care providers, teams and the relevant communities.	Conduct culturally competent research, such as community-based participatory research.
Professional							
Develop collaborative and respectful patient and collegial relationships that demonstrate awareness of issues regarding gender, sexual orientation, cultural experiences and the context of colonial and neocolonial Canada.	AS	1.1	Demonstrate integrity, compassion and respect for diversity; demonstrate humility and openness to learning from patients, families and others in the circle of care.	Develop and foster collaborative and respectful patient and collegial relationships that demonstrate gender, sexual orientation and cultural awareness.			
Identify and develop an approach to ethical issues that concern diverse populations, especially from a diversity, equity, inclusivity, anti-racism and anti-oppression framework.	AKS	1.3		Identify and resolve ethical issues in providing care for patients from diverse populations.	Develop an approach and promote dialogue on ethical issues that concern diverse populations.		
Collaborator							
Identify power differences and dynamics and take appropriate steps to address inequity owing to sociocultural forces within teams.	AS	1, 2	Demonstrate respect for diversity in working with teams.	Identify power differences and dynamics owing to sociocultural forces within teams, and contribute toward effective team building.	Resolve conflicts arising from power differences and dynamics owing to sociocultural forces within teams.		Provide consultation to teams and organizations to resolve conflicts and increase equity from a sociocultural perspective.
Identify, connect and collaborate with relevant community resources, including other physicians, health care professionals, agencies, religious leaders community leaders, healers and cultural consultants as appropriate to enhance clinical care.	KS	1, 2		Identify and facilitate patients to use relevant community resources.	Collaborate with relevant community resources to deliver integrated care.	Initiate connection with relevant community resources to explore new collaboration relevant for practice.	Develop a sustained collaborative relationship with community partners and facilitate collaboration among them.

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Table 1. (continued)

Role	Domain[b]	CanMEDS Enabling Competencies[c]	Transition to Discipline	Foundations of Discipline	Core of Discipline	Transition to Practice	Advanced Practice
Provide consultation and collaborate on initiatives effectively with other physicians, health care professionals, agencies, religious leaders, community leaders, healers and other providers for the diverse communities.	S	1 to 3			Provide collaborative consultation effectively to other physicians, health care professionals, agencies, religious leaders, community leaders, healers and other providers for the diverse communities.		Collaborate effectively on initiatives with other physicians, health care professionals, agencies, religious leaders, community leaders, healers and other providers for the diverse communities.
Establish a service plan in collaboration with service users and their families that promotes recovery and is based on the service user's own goals and an assessment of relevant strengths, resources, barriers and challenges. Identify how recovery principles can be implemented at all service levels.	ASK		Initiate, under supervision, discussions with the service user and family about goals for recovery, strengths, resources, barriers and challenges.	Explore the meaning and values that underpin the service user's recovery goals. Instill hope by helping to operationalize the service user's recovery goals into achievable steps.	Identify supports for key recovery goals, including relevant behavioural and physical health services, and peer-led and other nonclinical supports.	Establish a service plan in collaboration with service users and their families that promotes recovery and is based on the user's own goals and relevant strengths, resources, barriers and challenges.	
Leader							
Lead and participate in quality assurance and improvement in health care delivery that takes into account cultural, SDOH, and equity issues.	KS	1.1 to 1.4, 3			Participate in quality assurance and improvement in health care delivery that takes into account cultural, SDOH and equity issues.		Initiate, develop and lead quality assurance and improvement in health care delivery that takes into account cultural, SDOH and equity issues.
Promote equitable allocation of health care resources and access to care, while challenging responses that maintain or worsen inequity and the political-economic decisions that frame the issues and produce assumptions.	AKS	2.1, 3			Support initiatives that promote the equitable allocation of health care resources and access to care.		Initiate and promote initiatives that lead to equitable allocation of health care resources and access to care from a systemic level.
Health advocate							
Identify and address the impact of racism, oppression, access barriers and other sociocultural factors leading to mental health sequelae and health disparities in disadvantaged or marginalized patients and groups through individual and collective empowerment, mobilization and healing.	AKS	1.1, 2.1, 2.3	Identify the impact of racism, oppression, access barriers and other sociocultural factors leading to mental health sequelae and health disparities.	Address the impact of racism, oppression, access barriers and other sociocultural factors leading to mental health sequelae and health disparities in clinical care.	Address the impact of racism, oppression, access barriers and other sociocultural factors leading to mental health sequelae and health disparities in patients and their families.		Address the impact of racism, oppression, access barriers and other sociocultural factors leading to mental health sequelae and health disparities at the community level.

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Table 1. (continued)

Role	Domain[b]	CanMEDS Enabling Competencies[c]	Transition to Discipline	Foundations of Discipline	Core of Discipline	Transition to Practice	Advanced Practice
Identify and work with community-based, regional, national and international advocacy groups in mental health care, while critically assessing each group's place in the political and economic hierarchy.	KS	1.1, 2.1, 2.3	Identify advocacy groups in mental health care and begin to form connections.	Gain competency in modalities of advocacy, such as designing a campaign, liaising with politicians, writing letters, starting an initiative, etc..	Identify advocacy groups in mental health care, while critically examining the potential influence of health and pharmaceutical corporate interests.		Collaborate with local, national and international advocacy groups in mental health care.
Advocate with and for marginalized patients and communities to address the determinants of health, gender issues, oppression and equitable access to resources at the micro level (e.g., helping individuals obtain entitled benefits), mesolevel (e.g., ensuring anti-oppressive policies are enacted in institution) and macrolevel (e.g., identifying relevant policies, working with government, planning or participating in advocacy campaigns).	S	1.1, 2	Identify resources and aids available to address issues of inequity.	Advocate with and for marginalized patients to address the determinants of health, gender issues, oppression and equitable access to resources.	Advocate with and for marginalized patients and their families to address the determinants of health, gender issues, oppression and equitable access to resources.		Advocate with and for marginalized communities to address the determinants of health, gender issues, oppression and equitable access to, and distribution of, resources at the community/ system level.
Engage in culturally appropriate individual and community mental health promotion initiatives, such as community educational talks and workshops.	S	1.2, 1.3, 2.2, 2.3		Integrate culturally appropriate mental health promotion in patient care.	Facilitate culturally appropriate mental health promotion in families and/or patient groups.		Facilitate culturally appropriate mental health promotion in the communities.
Advocate effectively for the holistic needs, including biopsychosocial, cultural and spiritual needs of patients, families and communities.	S	1.1, 2.1, 2.3	Identify the holistic needs of patients, families and their communities.	Advocate for the holistic needs of patients and empower them in clinical care.	Advocate for the holistic needs of patients and their families.		Advocate for the holistic needs of patients, families and communities at the community/systemic level.

[a] Adapted from Rotation Specific Educational Objectives and Draft Milestones for Sociocultural Dimensions of Psychiatry developed by Fung K, Munshi A, Andermann L, and Pillar 4 Workgroup for the CBME Steering Committee, Department of Psychiatry, University of Toronto.
[b] A = attitude; K = knowledge; S = skill
[c] CanMEDS 2015 Enabling Competencies

Table 2. Core Themes in Cultural Psychiatry Curriculum

	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, Professional
II	Culture, Illness and Psychopathology	Identify and understand the impact of culture on symptoms, illness experience and psychopathology.	Medical Expert, 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, Leader, Health Advocate, Professional
IV	Culture and Health Care Policy, Services and Systems	Identify cultural and equity issues and challenges in policies, services systems, and research and develop strategies to address these gaps through advocacy, empowerment, research and mental health promotion.	Medical Expert, Communicator, Collaborator, Leader, Health Advocate, Scholar

competencies and milestones to facilitate curriculum design and implementation of teaching, while EPAs may be used to facilitate assessments and feedback. There will be a relatively small number of EPAs being developed to assess each stage of training. Cultural competence and safety needs to be *explicitly* included in the EPAs with the corresponding competency milestones mapped on to them as there is a tendency to erroneously assume that the dominant discourse, considerations and approaches adequately address the needs of marginalized or minority communities.

There are a number of specific considerations in designing and implementing a CBD curriculum in cultural psychiatry. First, there needs to be a shift in emphasis toward the teaching and attainment of observable clinical skills, away from didactic knowledge-based teaching. In cultural psychiatry, attitudes, knowledge and skills captured by some of the competencies are complex and may not be readily taught or observed in everyday clinical encounters, especially as they vary depending on the particular clinical context. Experiential learning through individual or group reflective exercises, the use of a "flipped" classroom with online resources and the increased use of simulation for cultural psychiatry teaching need to be developed. Second, as frequent work-based assessment and feedback are required, clinical supervisors not traditionally involved in cultural psychiatry teaching may need to facilitate the teaching and evaluation of cultural competence and safety, reinforcing the need for faculty development. Interprofessional and community partners who will increasingly be involved as collaborators or teachers also need to be engaged in this process. Finally, indicators of cultural competence need to be thoughtfully integrated with the new tools being developed to evaluate EPAs and competence milestones, including brief clinical evaluation exercises (mini-CEX) and similar paper or online assessment tools.

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.

As the objectives involve development of trainees' attitudes, knowledge and skills, a variety of pedagogical methods must be employed to facilitate learning, including: (1) individual or group reflective exercises and assignments in a safe environment to facilitate personal shifts in attitudes; (2) prescribed readings, didactic presentations and case studies to increase trainee's knowledge in key concepts and issues of providing care for diveserse populations; and (3) role-playing, observed interviews, direct patient care, and family and community interventions and collaborations to provide essential learning opportunities for skill acquisition through modeling, feedback and supervision.

These three sets of approaches overlap and reinforce one another. For instance, direct experience in working with a particular patient population not only increases clinical skills but may also lead to increased working knowledge as well as attitudinal shifts, especially if facilitated by appropriate supervision. The first two groups of learning activities may be actualized strategically and expediently through cultural competence seminars, case conferences and rounds, while the latter is most effective if ecologically integrated and embedded with the various rotations throughout the entire residency.[133] This latter integrative approach is a particularly important element in order to avoid conflating basic cultural competence with cultural psychiatry as a subspecialty applicable only to cultural

Table 3. Learning Objectives in a Cultural Psychiatry Core Curriculum.

	Topic	Objectives/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, racialization, ethnicity, gender 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 other forms of discrimination and oppression	Identify major social determinants of health relevant to Canadian context; including experience of Indigenous peoples, immigrants, refugees, racialized groups, and ethnocultural, gender and sexual 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 levels of individual, family and community.	AK
II	Culture, Illness and Psychopathology		
1	Explanatory model of illness, idioms of distress and cultural concepts of affliction	Distinguish between causal attributions, illness explanations, cultural idioms of distress and folk diagnoses.	KS
2	Cultural 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, healing and recovery	Understand how cognitive and cultural models influence coping strategies, help-seeking and health care utilization and the recovery model.	K
5	Cultural influences on psychopathology in major categories of disorder: mood, somatoform, dissociative, psychotic, substance abuse, 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 (e.g., in *DSM-5*: Other Conditions that May be a Focus of Clinical Attention).	K
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 models of cultural safety and cultural competence 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 conduct a culturally oriented interview to collect required information, organize and produce a cultural formulation.	KS

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Table 3. (continued)

	Topic	Objectives/Skills	Learning Objectives
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 well as cultural meanings of medications	KS
8	Culture, psychotherapy, and healing	Strategies for adapting psychotherapy (psychodynamic, CBT, family) to. intercultural work; interventions drawn from different cultures (e.g., mindfulness); strategies and interventions to empower and support healing, recovery and resilience of minorities and marginalized populations.	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 First Nations, Inuit and Métis populations living in urban, rural and remote settings.	AKS
3	Immigrant and refugee mental health	Recognize key issues in mental health of immigrants, 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

psychiatrists; rather, it reinforces the position that cultural competence is an essential and necessary core competence in every clinical encounter for every psychiatrist.[44] This training implication is that faculty members of all rotations need to receive training and support to maintain and improve their own basic cultural competence, as well as acquiring expertise to teach and evaluate it.

Community-based groups, institutions and organizations are important sources of knowledge and experience. They can offer support, guidance and information on the needs, illness models and histories of local groups which may be of significance in their exposure to risk factors for the development of health problems and their capacity to access and use services. They may offer specific services themselves that are more culturally consistent or, at times, may be a source of stigma and a barrier to people getting optimal mental health care. They are a potential useful ally in the development of culturally competent services as well as the individual development of knowledge. Knowing how to identify and develop working relationships with community-based organizations is an important skill 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 interinstitutional 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 translate this into a multisectoral intervention plan and (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. Training therefore needs to balance experiential learning that focuses on attitudes and enhances skills, with didactic and conceptual teaching that emphasizes models, methods and data.[38]

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. These may be grounded in their identity and personal history but also arise from aspects of collective experience of which they 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 and humility—while there is a common core of human experience that allows empathy across cultures, important details of each individual's background remain difficult to fully appreciate without extensive exposure over time to their social realities.[134] Thus, trainees who tend to be focused on mastery, acquiring professional authority and competence, must learn to tolerate ambiguity, uncertainty and not knowing—and develop the confidence to allow patients a measure of control over their own social positioning and gradual self-disclosure. 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 patients' identity, illness meanings, the social context of illness and adaptation and the clinical relationship itself.[135] 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 experience. 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 more open, personal exchange. Recognizing that clinicians each have their own unique life trajectories and cannot represent the diversity of any cultural group because of variations in social class, education and acculturation can reduce the tendency to stereotype.

To make use of their cultural knowledge, however, clinicians also need conceptual frameworks from cultural psychiatry and social sciences that make explicit the role of culture in health and illness. 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 indicators of psychological health and as goals for therapy reflects the dominant values of individualism. These are challenged by traditions that place a higher value of 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. These reflect not only the ethnocultural backgrounds of patient and clinician but also to the implicit values and ideologies that structure medical knowledge and the health care system.[136-138] 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: (1) establishing a working alliance in the context of power imbalances, divergent values and differing views of the world; (2) formulating problems in terms of specific social and cultural dynamics and (3) developing treatment plans that mobilize available resources and negotiating interventions with patients, their families and communities.

Intercultural work also requires tolerance for ambiguity.[126,139] 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 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- and person-centred and that can deal with uncertainty.[127]

Pedagogical methods useful for training in cultural psychiatry include:

1. *Case studies*: Clinical case conferences and other settings where individual cases are discussed provide a key method for learning the process and content of cultural formulation. Cultural formulations also serve to emphasize the importance of family, community and other social systems issues for many patients. The case study method, which is standard in medicine, can be used to analyze the complexity of cultural influences on patient presentation and evolution and also to identify the cultural dimensions of clinicians' positions and to work on biases and unexamined premises.
2. *Education in pluralism*: Cultural psychiatry rests on a basic respect for diversity in worldviews. This diversity includes notions of knowledge, authority and values that may be radically different. Working with such radical difference requires some understanding of philosophical and ethical notions of pluralism as well as skills in dialogical encounter that can be modeled and practiced in workshop settings with trainees and reinforced through clinical supervision.
3. *Experience with interinstitutional and intersectoral community work*: Although multidisciplinary cooperation is common in clinical settings, practical teaching about systemic issues is still largely inadequate. 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.[140,141]
4. *Fostering ethical reflection*: The predicament of refugees, ethnocultural minorities, and other vulnerable populations or marginalized groups raises complex ethical issues, involving individual versus group rights, as well as frequent situations where professionals must consider modifying standard procedures and adopting positions of advocacy without appropriating the voice or experience of the other.[142] 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 ethnospecific services can provide opportunities for more advanced training.[143,144] This may involve specialized inpatient, outpatient and community consultations as well as time-limited treatment.[145,146] These rotations usually involve clinical activities that include direct patient contact, consultation with referring clinicians and outreach to community referral sources. Because it emphasizes providing consultation to other professionals and requires openness to questioning the assumptions of standard psychiatric practice, 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, confidence and an effective clinical approach.

Research Training

Research in Canada has documented clear disparities in access to mental health services and outcomes for different groups. There is evidence that specifically addressing cultural differences can improve access to care and clinical outcomes. However, 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. This, in turn, requires a new generation of researchers trained to apply contemporary social science perspectives and diverse methods to the study of culture and psychiatry. To address issues of cultural diversity in mental health services, researchers require familiarity with a broad range of methodologies. The most sophisticated studies are multilevel and multimethod, integrating both quantitative and qualitative approaches, and require teams of researchers who can work together closely to consider the various levels at which culture has an impact, from the individual through to the broader society. Research with Indigenous 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 rigor and learning to question one's own discipline through other perspectives.[48]

Assessment in Training and Continued Medical Education

A well thought-out assessment process is an essential component to cultural competence training in residency as it not only provides a summative evaluation of the trainee but can also provide formative feedback that facilitates learning and a motivational incentive to continuously reflect, learn and make behavioural changes. Assessment and evaluation are the cornerstones of curriculum development. For trainees and practitioners, evaluation is a strong motivator for learning and can help the clinician to identify areas where they need additional experience. In the area of cultural psychiatry and cultural competence, developing valid and reliable evaluation tools can be a challenge as the real goal is to effect meaningful changes in attitudes and clinical skills that continue to develop through experience and persist long after the course materials have been delivered; testing factual knowledge delivered in the course is much more straightforward using traditional means. 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 ASK [attitudes/skills/knowledge] model of cultural competence) with the objective of creating valid evaluation tools.[44]

Attitudes can be assessed through reflective journaling 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 (OSCEs), mini-CEX, 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 Royal College 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 because successful performance in oral examinations remains one of the core requirements for successfully completing psychiatric training. These components can be adapted and integrated with existing scoring sheets and can be used for formative feedback in regular practice interviews as well as final evaluative examinations.

Table 4. Evaluation Template for Observed Interviews and Case Presentation[a]

1.0 Physician–Patient Relationship
- Engages patient in a culturally appropriate manner

2.0 Interview and Mental Status Exam (MSE)
- Appropriately adapts the interview and MSE to be cultural competent.
- Interview content.
- Identifies social and cultural stressors and systemic inequities.
- Explores 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 bio-psycho-social-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.

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 multisource ("360-degree") feedback as an evaluation methodology, and this is particularly relevant in assessing the core cultural competence of working with the diverse communities as a medical expert, collaborator, and leader. Depending on the rotations, the multisource feedback should include considerations of input from supervisors, interdisciplinary health professionals, relevant community partners, and if possible, patient and family feedback.

Faculty development is critical to the success of the cultural competence training.[147] With all the activity in postgraduate curricula in cultural competence training, offering CME programs to existing faculty becomes very

important to enhance awareness of content and concepts within the expanded residency curriculum and to improve their supervisory skills by adapting cultural competence within their own specialty areas. The 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, and this would include all mandatory clinical rotations, psychotherapy supervisors and electives. Cultural competence can also be assessed at the level of organizations.[148] This is an essential complement to efforts directed to 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 can and should be diverse. Senior faculty, junior faculty, residents and community members can be involved. The exact configuration will depend on local availability and the strategy for implementation, but the diversity does offer the possibility of different parts of the leadership being tasked with and owning different parts of the curriculum. Developing a common understanding in the leadership through a facilitated workshop focused on producing a local curriculum helps to fuse the leadership. The plan and implementation strategy flow from the CPA curriculum, local needs and the time and resources available, including the expertise that the leadership team has at its disposal.
2. Resources needed for the plan are mainly the time of residents, faculty and community. The knowledge may be taught by a number of different methods including, text, lectures in person or via webinars and seminar series. Attitudes may be taught by various methods including self-reflection, group work and exposure over time to different communities. However, clinical skills are best improved by practice and coaching. This requires supervisors themselves to be conversant with approaches to cultural safety and cultural competence or for other sources of expertise to provide support to trainees on this issue. The amount of training of supervisors that is required will vary depending on their role. Exposure to the work of community groups and specific 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. Part of implementation, therefore, 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

The accelerated exchange of knowledge and the confrontation of different value systems and perspectives that come with globalization are 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. At the same time, social sciences and cultural neuroscience can provide psychiatry with conceptual models for integrative understanding of mental health and illness.

The Section on Transcultural Psychiatry of the CPA has contributed to the Multicultural Mental Health Resource Centre (MMHRC; www.mmhrc.ca), an online knowledge exchange centre to support intercultural mental health care. In addition to material for patients and practitioners, the MMHRC has sections to share curriculum materials, interactional learning, and self-assessment tools, as well as models of clinical practice and organizational change.[149] Continued Professional Development activities in this area include the annual Summer Program and Advanced Study Institutes in Cultural Psychiatry organized by the Division of Social and Transcultural Psychiatry at McGill University and an annual Cultural Psychiatry Day, which is a nationwide accredited videoconference event, cosponsored by the Transcultural Section of the CPA. These initiatives support ongoing efforts to make cultural psychiatry a core component of the knowledge and skills of all psychiatrists. Of course, these professional competencies need to be coupled with institutional changes and monitored by accreditation bodies, to ensure that all Canadians benefit from a culturally safe and competent mental health care system that responds to the needs of our diverse society.

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