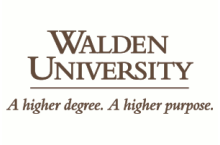

2020

Psychiatric Residents' Perceptions of Cultural Competency Training for Mental Health Care Delivery

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This is to certify that the doctoral study by

Carol A. Matthews

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2020

Abstract

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MSW, Adelphi University, 2007

MS, Iona College, 1995

BS, Marymount College, 1983

Project Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Considering and respecting patients' cultural needs is integral in providing culturally competent mental health care. In 2013, an urban community hospital conducted the Community Health Needs Assessment with patients, community stakeholders, and health care providers. The assessment revealed the need to address a more diverse patient population with culturally different health needs through training culturally diverse health care providers. Thus, the focus of this qualitative case study was on how the academic training of psychiatric residents in cultural competency affected the delivery of culturally responsive mental health patient care. The conceptual framework of Jeffery's cultural competence and confidence model grounded this study in understanding the process of teaching and learning cultural competence. The research question related to how psychiatry residents perceived their cultural competency training in the delivery of culturally appropriate mental health care. Data was collected from eight psychiatric residents. Through a qualitative data analysis of the focus group, field notes, and review of training materials, the findings provided a detailed description of the residents' perspectives of their cultural competency training. The focus group discussion with the residents was transcribed, coded, and analyzed for themes in the impact of the cultural competency training. Residents' perceptions suggested training enhancements in an understanding of the diverse patient's culture, language differences, and community are weaved into the cultural competency clinical training. This study supports social change in its benefit to culturally diverse patient populations in understanding the importance of cultural competency training in the delivery of quality mental health care.

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Dedication

This paper is dedicated first to my Lord and Savior, Jesus Christ, who said, "If you can believe, all things are possible to him who believes" (Mark 9:23, New King James Version). Secondly, to my husband, Edwin W. Matthews, III (EW), through your love and encouragement, missed vacations, missed family gatherings, and plenty of take–out meals kept me believing that I could do this!" My daughter, Keisha S. Roberts, who since birth has been the "wind beneath my wings." My other daughter, Jamiilah, your strength and determination for life is an inspiration to me. To my grandchildren, Jacqueline, Dyshaia, Big Zaire, Aiyanna, Little Zyaire, Lauren, and Kaden, I hope I have inspired you to believe that, "not even the sky can limit you." Dream big and achieve even bigger things in your lives. To my nieces and nephews, I paved the way for you to blaze the future trails. Set this world on fire! To my sisters, Dolores, Jeanna, and Barbara, always encouraging me to chase my dreams. To my extended family and friends, for always keeping me lifted in prayer and sending me words of encouragement. I promise this is the last degree. Lastly, (but certainly not least), Laticia R. Mitchell, for your endless support, love, and encouragement, I could not have done it without you.

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Table of Contents

List of Tables

Section 1: The Problem

Introduction

As the population in the United States becomes increasingly diverse, it is necessary to ensure that healthcare delivery meets the medical, psychological, and social needs of patients in a culturally competent manner. At a New York City (NYC) public hospital, cultural competence has a multifaceted complexity due to the cultural diversity of physicians and service providers in conjunction with a diverse patient population. As a NYC public healthcare organization, it has a moral and legal obligation to ensure the cultural competence of service providers and culturally responsive and relevant care to their diverse patient population.

Understanding the problem requires a description of the institution, staff, and patient population. The study site is a 282-bed urban municipal community-based hospital that provides a range of preventive, primary, and acute care services, including inpatient and outpatient psychiatric and substance abuse services. A profile of the communities served by this urban community hospital indicates most patients sit at or below the poverty line, and between 40% to 60% receive some public income support such as cash assistance, temporary assistance for needy families, supplemental security income, or Medicaid.

The NYC public hospital's mental health providers are culturally diverse but culturally different than their patient population. Currently, 60% of mental health services in NYC are provided by NYC public hospitals ("Community Health Needs," n.d.). In 2019, the ethnic composition of the study site's primary service area included 65%

African Americans, 22% Hispanics, 3% Whites, 10% Other, and <1% Asians ("Community Health Needs," n.d.). In contrast, the 28 primary mental health care providers (psychiatric residents) in the outpatient clinic identified as African and African American (43%), Indian (18%) Pakistani (14%), and other (Russian, Haitian, Columbian, Iranian, and American-born (<1%). Twenty-two percent of patients in service at the urban community hospital spoke a language other than English at home. The rich ethnic and racial diversity of both the community and the psychiatric residents set the backdrop and the foundation for this research.

To determine the hospitals' effectiveness in the delivery of its health care services to their culturally diverse patient population, for the first time in 2013, the study site conducted and published a Community Health Needs Assessment (CHNA) from focus groups with ambulatory care patients, health care providers, and community stakeholders. The assessment was conducted to report community health needs in-depth, prioritize healthcare issues based on the responses and to address and develop culturally and linguistically appropriate programs and services to meet the complex medical and social needs of the study site's patient population. The participants in the CHNA answered several questions related to the delivery of healthcare at the study site. Although ranked differently among each group, the participants identified heart disease, diabetes, hypertension, obesity, and mental illness as primary health concerns of the health care consumers of the study site. The outcome of the 2013 CHNA established the foundation of this study by providing an insight into what the community stakeholders, health care providers, and patients want and need to receive culturally competent quality health care.

According to the 2013 CHNA, the strengths and weaknesses of the current health care services varied among focus groups. A strength expressed by the health care providers was satisfaction with the complementary nature of the staff and the culturally diverse patient population. Similarly, the community stakeholders listed culturally and religiously sensitive healthcare services and programs as a strength. However, the health care providers recorded dissatisfaction with staff training and the need to meet the increased demand for language interpreters as a weakness of the current health care service at the study site. Thus, the responses suggest a presence of a culturally diverse staff but also a need to strengthen staff training and the development of culturally appropriate services to the study site's community due to challenges with cultural diversity among patients, providers, and community stakeholders at the urban community hospital.

To meet the needs of a growing diverse patient population means increasing the demand for a culturally competent health workforce (Sopoaga, Zaharic, Kokaua, & Covello, 2017). Mental health contributes to a significant role in the health and well-being of individuals and communities in the United States and the world (DelVecchio Good & Hannah, 2015). In 2016, the study site conducted a second CHNA, which ranked mental illness as a health need, suggesting a closer investigation of the cultural differences between patients and providers in the delivery of mental health services. At the study site, mental health care was listed as the third-largest ambulatory care service providing mental health services to approximately 42,000 health care consumers in 2016. The study site also serves as a teaching institution utilizing psychiatric residents as the

primary mental health providers in the outpatient services. To provide culturally sensitive mental health care, which meets the needs of the study site population, the psychiatric residents participate in a single cultural competency training.

The problem that informed this study originated from the outcomes of the 2013 CHNA focus groups that suggested establishing appropriate cultural services, providing better patient relationships, and improving practitioners' satisfaction with training. Additionally, a 2019 CHNA echoed the voices of residents from 2013 and 2016, reporting the daily challenges of poverty, violence, and poor living conditions continue to affect the physical and mental health of community residents. In 2019, mental illness continued to rank within the top five challenges faced by the residents in the study site's community.

This investigation was focused on a review of the cultural competency training strategies at the study site on the perceptions of psychiatrists about their medical education in cultural competency. The purpose of the research was to understand the perceptions of a culturally diverse group of third-and fourth-year psychiatric residents concerning their cultural competency training. With better understanding of this training, this research was intended to improve future professional cultural competency training in meeting the health care needs of the culturally diverse patient population of the study site.

The Local Problem

To evaluate and prioritize the most significant health needs of the neighborhoods and communities, the largest NYC public health care organization conducted a comprehensive and inclusive process to complete CHNAs. The findings represented the

voices of the patients who are served, clinical experts, and community partners, which are backed by quantitative data analysis. For instance, the 2013 CHNA provided a detailed overview of study site's services, its patient population, and the cultural difference among patients, providers, and community stakeholders. It also highlighted and ranked mental illness as a health need and the hospital site as the provider of mental health services. The outcome of the 2013 CHNA suggested a closer investigation of the cultural differences between patients and health care providers, and the providers' training in the medical treatment of the culturally diverse patient population of the study site.

The responses of health care practitioners are important because the doctor–patient relationship influences patient engagement. A patient-centered perspective improves the quality of care, healthcare, and health outcomes (Green et al., 2017). Additionally, it is important to establish a strong therapeutic alliance across cultural lines that promote participant engagement in cross-cultural experiences (Knecht, Fontana, Fisher, Spitz, & Tetreault, 2018). Cultural knowledge requires some degree of immersion and an open and trusting relationship so patients can express themselves (Knecht et al., 2018). The therapeutic relationship is most at risk when practitioners demonstrate low levels of cultural competency. Therefore, the goal of medical training programs, among mental health providers, should include cultural competency training in the delivery of culturally responsive psychotherapy.

Cultural competence describes a set of practices, attitudes, and procedures that enable agencies, organizations, and health care professionals to interact with other cultures (DeSilva, Aggarwal, & Lewis-Fernandez, 2015; Jackson, 2015). Cultural

competency addresses cultural differences between health professionals and patients who have differing health beliefs and practices to Western biomedicine (Jongen, McCalman, & Bainbridge, 2016). Components of cultural competence include diverse intervention strategies that target health practitioners, health organizations, and health systems (Jongen et al., 2016). Cultural competency training involves knowledge, attitudes, skills, and behaviors to promote cultural awareness. The study site's psychiatry residency training program's cultural competency training evolved by utilizing the DSM-5 cultural formulation interview. This evidence-based tool is composed of a series of questionnaires to assist clinicians in making person-centered cultural assessments in the psychiatric diagnosis and treatment of a culturally diverse population (DeSilva et al., 2015).

Meeting the needs of the current culturally diverse patient population suggests training health professionals in cross-cultural care. The outcomes of the 2013 CHNA, coupled with the practitioners' understanding of the importance of effective communication with diverse populations, highlighted a need for cultural proficiency. Cultural proficiency sets the standard for developing cultural competence and places the understanding of culture at the center of positive engagement among patients and their families in the delivery of culturally responsive healthcare. Therefore, this study was intended to understand the perspectives of the psychiatric residents in their medical training in cultural competency. The results of the study will not only be meaningful to the patients but also the psychiatric residency training program and the psychiatric residents in the delivery of culturally appropriate mental health care services at the study site.

Rationale

The outcome of the 2013 CHNA suggested a closer investigation of the cultural differences between patients ,health care providers, and the providers training in the medical treatment of the culturally diverse patient population at the study site. The 2016 CHNA further suggested that the distinct cultural differences between the patients and the psychiatric residents served as evidence regarding the need for training in cultural competency. Additionally, former psychiatric residents suggested additional training modules with supplementary information on particular cultures would have helped in bridging the cultural divide among residents and patients. When asked about their cultural competency training sessions, they suggested role playing to demonstrate techniques that could have been used to improve patient-provider relationships. A former residency training director suggested cultural competency training should happen sooner than the second year of residency training to help meet residents' needs in the delivery of culturally competent mental health care at the study site.

Frequently, cultural barriers that exist between patient and practitioner prevent members of minority populations from receiving appropriate care. Reasons for obstacles are often mistrust and fear of mental health treatment, different perceptions about what constitutes illness and health, common language obstacles, ineffective communication due to cultural differences, and the diverse mental health workforce (Mobula et al., 2015). At the study site, the cultural differences between providers and patients have been identified as what lead to discrimination. According to a provider at the study site, cultural differences have caused bias in providing mental health services, preventing the

minority population from seeking help. In a multicultural setting, such as at the study site, the delivery of health care is hampered by language barriers as well as nonverbal communication between the medical provider and the patient. However, the global immigration of medical residents has resulted in a diverse workforce at the hospital, which has led to a quasi-appropriate delivery of culturally appropriate mental health care.

Another obstacle to care is that culturally insensitive medical training approaches perpetuate distrust in and underutilization of mental health services by minority populations, which widens health care disparities (Mobula et al., 2015). The term *disparity* in health care refers to the differences in the delivery of health care and the inequality experienced among the diverse population (Seeleman, Essink-Bot, Stronks, & Ingleby, 2015). Thus, the call to reduce health disparities in the United States has become a significant concern in the medical community and the core of medical education and clinical training (Mobula et al., 2015). This study was conducted to gain the perspectives of third- and fourth-year psychiatric residents regarding their cultural competency training at the study site. The study sought to understand if the study sites' psychiatric residency training in cultural competency is meeting the residents' needs to deliver culturally responsive mental health care to the diverse patient population at the hospital.

Definition of Terms

The intent of clinical training of health care providers in cultural competency is to provide an efficient, equitable, and respectful cultural response to the diverse cultural health practices, beliefs, and communication needs of patients. The definitions in this section foster an understanding of keys terms needed to successfully navigate medical,

cultural competency training and aid mental health practitioners to work effectively with culturally diverse populations.

Community Health Needs Assessment (CHNA): A designed assessment composed of primary source information collected from three focus groups conducted by study site in 2013, 2016, and 2019 to help report community health needs.

Culture: It is integral to every person's life. It defines a system of beliefs, perspectives, and values of a group of a particular race/ethnicity or geographic region collectively share (Garneau & Pepin, 2015).

Cultural competence: The definition of cultural competence most cited in the scientific literature is from Campinha-Bacote (1999) which defines "the process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of a client [individual, family, or community]" (Garneau & Pepin, p. 10, 2015).

Cultural competency: It can be defined as the attitudes, knowledge, skills, and values that an individual develops over time and uses to work effectively in a cross-cultural environment (Prescott & Noble, 2017).

Health disparities: A type of health difference that is closely linked with social or economic disadvantage. Health disparity is a specific type of health inequality that denotes an unjust difference in health. By one standard definition, when health differences are preventable and unnecessary, allowing them to persist is unjust (Arcaya, Arcaya, & Subramanian, 2015).

Resident: An individual enrolled in an Accreditation Council for Graduate Medical Education [ACGME] -accredited residency program (Accreditation Council," 2018).

Transcultural: Implies comparative interactivity among cultures (Jeffreys, 2015).

Transcultural self-efficacy: The perceived confidence needed to perform or learn general transcultural skills required to deliver consistent, culturally responsive health care among culturally different clients (Halter et al., 2015).

Significance of the Study

Cultural competency training builds the capacity of mental health care workers to work in therapeutic settings with clients from diverse backgrounds. The importance of this study centered around a review of the study sites' globally diverse sample of psychiatric residents treating a culturally diverse patient population and an analysis of the psychiatric residents' perceptions of their cultural competency training. The outcome of this qualitative research may impact the delivery of culturally sensitive mental health care training programs. When culture is not considered in the treatment of mental healthcare, management may be adversely affected. Not only is treatment impacted, but health care inequities are created and experienced predominately among diverse populations.

The inclusion of culture and diversity are positive influences in social change, as the integration of social context and social determinants of patients is valuable (Sopoaga et al., 2017). When mental health care systems do not incorporate the histories, traditions, beliefs, and values of culturally diverse clients, it contributes to health care disparities. However, culturally sensitive teaching strategies can reduce health care disparities and

inequities to foster socially healthier communities. To attain cultural competency among health care providers and organizations, training is a complementary strategy to improve the quality of care delivered to diverse patients to reduce health care disparities (Mobula et al., 2015). To understand the perspectives of the study site, psychiatric residents would provide a basis for a critique of the study site's psychiatric residents' training in cultural competency. Therefore, my task was to provide an unbiased, clear picture of a group of culturally diverse psychiatric residents' perceptions of their current training and learn their training needs in delivering culturally appropriate mental health care to their patients.

Research Questions

This qualitative case study involved investigating the perceptions of a group of culturally diverse, third- and fourth-year psychiatric residents and their medical training in cultural competency. The goal was to understand whether they perceived their training in cultural competency was meeting their needs in the delivery of culturally appropriate mental health care at the study site. Thus, the central research questions that were investigated were:

RQ1: How do psychiatry residents perceive the impact of their cultural competency training in the delivery of culturally appropriate mental health care?

RQ2: How do psychiatry residents perceive the value of cultural competency training in the provision of culturally sensitive mental health care?

RQ3: How do psychiatry residents perceive their current medical training in cultural competency concerning their careers in culturally different communities?

Review of the Literature

An analysis of the current literature suggested the meanings, benefits, and practices of integrating cultural competency practices in working with diverse populations. Additionally, in the review of the literature, appropriate strategies emerged to increase the knowledge and skills needed when working with members of various cultural groups. The concept of integrating cultural competency training in medical education arose as a strategy that contributes to better patient-provider engagement, meaningfulness, and mental health treatment among culturally diverse populations.

Conceptual Framework

The conceptual framework that informed this research in understanding the process of teaching and learning cultural competence is Jeffrey's (2015) cultural competence and confidence [CCC] model. The CCC model was built on Bandura's self-efficacy theory that addresses learning, motivation, persistence, and commitment to cultural competency development. Self-efficacy is strongly connected to perseverance and the power within a person, which creates actions that lead to success in learning. Therefore, self-efficacy becomes a significant determinant in learning cultural competence and the foundation for the CCC model (Halter et al., 2015).

The CCC model is a framework used to study the multidimensional components embodied in the process of learning cultural competence (Jeffreys, 2015), which is required to address health disparities, improve patient outcomes, and retain a diverse workforce (Halter et al., 2015). The CCC model also serves as an educational strategy and design for the implementation, evaluation, and learning or developing cultural

competence (Jeffreys, 2015). The model suggests learning experiences coupled with formalized education, influence transcultural self-efficacy and transcultural skill development (Halter et al., 2015). The CCC model promotes transcultural self-efficacy or the perceived confidence needed to provide culturally congruent health care through supporting cognitive, practical, and effective skills. The cognitive component of cultural competence focuses on the knowledge and understanding of cultural beliefs and practices (Jeffreys, 2015). The functional component relates to the ability to interview clients and conduct a cultural assessment, and the active part is used to examine attitudes, awareness, appreciation, and specific interventions essential in cultural competence development and culturally congruent care (Jeffreys, 2015).

This conceptual framework established the educational basis for training medical professionals in the interaction with culturally diverse populations and communities. Utilizing the CCC learning model in this qualitative research design provided an understanding of the residents' cultural competence skills development, the residents' perceptions of learning or developing cultural competence, and informal observations of the residents' level of confidence in specific transcultural skills.

Review of the Broader Problem

History. The United States census suggested that the diversity of the United States population will increase in both number and diversity (Vollman, Healey, Pettway, & Jackson, 2016). By the year 2044, more than half of the American people will identify with a minority group, and by 2060 foreign-born residents will increase exponentially

(Vollman, Healey, Pettway, & Jackson, 2016). This change in the diversity of the population of the United States is a growing challenge for health care professionals.

For more than 20 years, cultural competency training has been at the center of medical education (DelVecchio Good & Hannah, 2015). Cultural competency came into effect because of the differences between caregiver and patient (Turner et al., 2016). Cultural competency efforts also emerged because of knowledge deficits present among medical students upon arrival to medical training (Jernigan, Hearod, Tan, Norris, & Buchwald, 2016; Prescott & Nobel, 2017). Health care providers have often arrived with these skill deficits hindering their understanding of cultural beliefs and values of patients whose backgrounds were different from their own (Henderson, Horne, Hills, & Kendall, 2018). The influence of societal inequities on health established the need for cultural competency training; medical education needs to highlight the significant importance of social, political, and economic factors on health outcomes (Neff et al., 2017). Cultural competency training addresses cross-cultural issues of illness and health to counteract the marginalization of patients due to race, ethnicity, social class, religion, sexual orientation, or differences which can reduce racially and ethnic health care disparities (DelVecchio Good, & Hannah, 2015; Turner et al., 2016).

Cultural competence is the presence of a medical provider's cultural awareness, knowledge and skills necessary to efficiently obtain medical history, enabling them to diagnose and treat the patient (Henderson et al., 2018). With cultural competence as the basis for change in medical training, the Accreditation Council for Graduate Medical Education [ACGME] became a promoter of competency-based training for all physicians

in the United States (ACGME, 2018). ACGME is responsible for establishing cultural competency milestones expected of residents and fellows after their training. Therefore, a trainee who is ready for unsupervised practice should be able to formulate a therapeutic relationship with patients and caregivers of different socioeconomic and cultural backgrounds (Easter et al., 2015). Through the efforts of the ACGME, there has been a redesign of medical training to develop practitioners who can discern cultural variables that produce and racialize inequalities in health care as well as reduce patients' experience of the stigma of health inequities and improve health outcomes.

Benefits. The need for improvement in cultural competency training was established in the surgeon general's 2001 investigation into health care disparities, which described the magnitude of the problem as unequal treatment and significant racial inequalities and disparities in health care in the United States (DelVecchio Good & Hannah, 2015). There is a need for health care organizations to implement cultural competency practices because their policies and practices are one of the many factors influencing inequality in care, which cultural competency training can address (Weech-Maldonado et al., n.d.). Culture is essential to mental health practices, and its significance can shape clinical presentation, doctor–patient interactions, the illness experience, and the communication of symptoms (DelVecchio Good & Hannah, 2015). In communities where there are residents that are multicultural, multiethnic, and multifaith, there are persistent inequalities in the use of mental health care services due to a cultural divide (Avila, Kamon, & Beatson, 2016). To begin to reduce racial and ethnic disparities in health care services will require the implementation of both culturally responsive and

linguistically sensitive services to improve the nation's overall health outcomes (Avila et al., 2016). Therapeutic alliance is needed across cultural lines, and culturally-appropriate services are contingent upon the cultural competency training extended to mental health residents (Duane, Caputi, & Walker, 2018).

Developing clinical competency begins with the education of the workforce about cultural differences and what influences patients' understanding of health and illness (Avila et al., 2016). It is important for psychiatrists to learn to see patients in their cultural context as well as consider their cultural values and prejudices in treating a cross-cultural patient population (Schoyler-Ocak et al., 2015). Thus, the attitudes and professional experiences of healthcare workers are important in developing functional and practical trainings that are endorsed by the professionals the training was designed for (Shepherd, Willis-Esqueda, Newton, Sivasubramaniam, & Paradies, 2019). The addition of evidence-based practices that integrate and build on cultural understanding can be beneficial to the current cultural competency training modules (Schoyler-Ocak et al., 2015). There is also a need for standardization of health professional cultural competency training and delivery on the importance of culture when working and collaborating with individuals seeking mental health services (Avila et al., 2016). Program administrators need to take the lead in providing additional training in the implementation of culture into cultural competency medical training of the psychiatric residents (DelVecchio-Good & Hannah, 2015; Scholyer-Ocak et al., 2015).

Identifying the cultural needs among the workforce and health care organizations highlight ways to improve cultural responsiveness, effectiveness, and the appropriateness

of clinical treatment (Duane et al., 2018). It is important for clinicians to not only be aware of distinctions in cultural differences but also consider the uniqueness of diverse populations and apply the identified guidelines to provide the most comprehensive mental health therapeutic care (DelVecchio Good & Hannah, 2015). Additionally, in mental health care, developing a strong rapport between the patient and therapist can aid mental health providers in conducting appropriate clinical assessments and improving patient access to culturally competent health care (DelVecchio Good & Hannah, 2015).

The reduction of the stigma and discrimination centered on mental illness is also a noted concern of healthcare providers. Stigmatization may be the result of a lack of skills among healthcare providers, and may be connected to a lack of comfortably communicating with and treating persons with mental illnesses (Ungar, Knaak, & Szeto, 2016). Training and development among healthcare providers is an emerging component in anti-stigma programming to include individual learning and suggest a human-centered strategy as a way to reduce mental illness stigma in healthcare (Ungar et al., 2016).

Cultural competency is recognized as a much-needed skillset for all mental health professionals (Henderson et al., 2018; Jernigan et al., 2016). For decades, clinicians have investigated means to reduce health and health care disparities. Research has indicated that when cultural competence is addressed at all levels of the health care organization, health disparities can be reduced.

Mental illness. Mental illness impacts the quality of life for many individuals. Fear, rejection, and discrimination have prevented minority populations from seeking help needed or continuing in treatment to attain mental health. The stigma of mental

illness has also created prejudice and discrimination for individuals and family members seeking services. Though positive trust can result from ethnic similarities between patients and their providers, lack of confidentiality, differences of culture between patients and their providers, and stereotyping and disrespect are still barriers to trust (Aggarwal et al., 2016c). Therefore, race, ethnicity, and culture are important in the relationship between the participant and provider. Patient cultural views and institutional challenges and clinicians' biases can be barriers to care, but mental health programs that embrace and enhance culture and equality in service can reduce mistrust in and underutilization of mental health services by minority populations (Aggarwal et al., 2016c).

The omission of culture. The call to reduce health disparities and provide culturally responsive health care in the United States has become the primary concern in the medical community and a key component of medical education and clinical training. However, a common theme in the literature suggests silence or avoidance of the discussions about culture, race, and privilege lends itself to pedagogical difficulties and room for improvement in cultural competency training in medical institutions. For example, DelVecchio-Good and Hannah (2015) sought to understand how American medical health care staff responded to cultural diversity and how culture makes a difference in healthcare, particularly in mental health. They explored how concerns such as culture, ethnicity, immigration, diversity, disparities, and inequalities influence clinical ideologies, form clinical practices, and design programs to deliver quality care that is culturally appropriate, sensitive, or competent.

Therapeutic relationships. The literature has highlighted the ongoing concerns of psychiatric residents in their cultural competency training, which emphasize residents' awkwardness of race talk, the unspoken discussions of race, and the negative impact it has on cultural competency training. Patient care must include appreciation for patient values and belief systems to provide optimal success in delivering successful patient outcomes. Knecht et al. (2019) found a significant difference in knowledge, skill, encounters, and desire of 25 female nursing students who participated in training in a diverse clinical setting. Three themes also emerged from the results which included: enlightenment, competence, and connection (Knecht et al., 2019). Student competence was also revealed in their presence during diverse community encounters and their ability to assist, although minimally. Lastly, the formation of reciprocal relationships emerged as evidence of connection and understanding being important to therapeutic alliances (Knecht et al., 2019). The implications of these results supported the current study's intent to understand what medical providers need in cultural competency training strategies in developing therapeutic relationships with a diverse patient population.

Cultural competency training. A closer look at the study site's psychiatric residency training will help understand if training in cultural competency improves the complementary nature of medical education in the delivery of culturally appropriate mental health care. Jerigan et al. (2016) highlighted the continued need to monitor and address health care policies and practices to result in a reduction in health care disparities and the induction of effective cultural competency training of health care professionals. In this study, a two-stage literature review was used to examine and assess pedagogical

approaches to cultural competence training in United States medical education to address best practices in cultural competence training and improving cultural competence training efforts medical and public health programs. The researchers suggested cultural competency training intends to have medical professionals learn approaches that will assist in the cultural awareness, racial, ethnic, and cultural identities of their patient population. This study is in support of the health professional learning new approaches to improve communication, deliver of quality, culturally responsive health care, and reduce of health care disparities. The increase in a multiracial and multiethnic population will require a change in the delivery of health care to meet the changing demographics of the United States population seeking health care.

Jenigan et al. (2016) study provided a systematic review of training and programs that used the tool for assessing cultural competence training. Eighteen applications were assessed. Stage I of the narrative review indicated 18 articles on 18 programs used the tool for assessing cultural competence training. Stage II of the literature review evaluated the incorporation of the tool for assessing cultural competence training domains. The study results revealed a considerable variation in cultural competence training across medical schools leading to differences in program quality and outcomes. The reviewed studies determined the effectiveness of patient-centered models that include a cultural competence perspective in the improvement of health outcomes among diverse patient populations is needed. If the goals of medical training are to develop physicians free of biases and being capable of addressing the health needs of a diverse patient population, the attainment of this goal continues to be an ongoing challenge.

Jenigan et al.'s (2016) study revealed the significant socioeconomic and racial disparities between physicians and patients. Also, it highlighted the difficulties of defining, applying, and assessing cultural competence in medical education. It proved healthcare training programs in cultural competence require an ongoing review of cultural competency training among medical schools. This study's physician-patient participants identified as similar to the ethnic composition of the population at the study site. The recognized relationship makes this study beneficial in understanding the unique cultural needs of disadvantaged minority groups and what it takes to deliver culturally competent psychiatric health care. The study reported health care providers needed to work toward the development of cultural tolerance and liberal attitudes, respectful interpersonal behaviors, and skills to communicate with culturally diverse patients effectively. In addition, the evidence of the study highlighted the need for health care providers to develop continued motivation in enhancing the development of knowledge regarding culturally competent health care.

Cultural competence. Jackson (2015) defined a culturally competent individual as one who has social mindfulness, social information, and down to earth diverse aptitudes, has occupied with self–appraisal for predispositions and generalizations, and perspectives all conduct in a social setting. From the organizational level, cultural competence values diversity, conducts self-assessment, manages the dynamics of difference, clarifies the organization's vision, institutionalizes cultural knowledge, and adopts policies and procedures to ensure cultural responsiveness to its diverse population (Jackson, 2015). The implementation of culturally competent health care begins at the

macro level of the organization, implementing strategies for delivering culturally appropriate health care, such as in the psychiatric residency training program. In a review of seven articles on cultural competency, Govere, and Govere (2016) indicated evidence that suggested interventions in organizations conducted by providers to improve cultural competency had a positive impact on cultural competence of the healthcare.

Organizational and systematic cultural competence. Jongen, McCalman, and Bainbridge (2018) described cultural competence as a strategy for eliminating racial and ethnic health disparities across healthcare systems and an approach to improving health service for culturally and ethnically diverse groups. This framework takes the focus away from the practitioner and puts it on the organizational system. The authors offer strategies that could be applied to health care organizations to assist in internalizing and committing to improving cultural competence and reducing health disparities.

According to Weech-Maldonado et al. (2018), health care organizations' policies and practices are significant factors that influence disparities in the delivery of quality health care. As such, the implementation of cultural competency has been suggested as a strategy to address these disparities. For organizations to achieve cultural competency could be accomplished through policy implementation, learning processes, and structures that develop the attitudes, behaviors, and systems for effective cross-cultural interactions. Weech-Maldonado suggested successful implementation of cultural competency would require an organizational commitment to ensure the organizations' structure of people, policies, and practices are enacted in unison to achieve the goal of a culturally competent organization.

Culturally competent organizations represent the capacity to effectively provide services that reflect the different cultural influences of their clients. Weech-Maldonado et al. (2018) offered successful cultural competency care strategies as (a) patient-provider communication to include interpreter services, translated materials for limited English speaking patients; (b) care delivery and mechanisms such as the delivery of care and links to supportive services and providers; (c) providing administrative support to enhance policies and standards of cultural competence for the entire organization; (d) developing agency-wide action plans to implement realistic cultural competency goals, and lastly (e) establish a culturally competent workforce through formal recruitment strategies and the implementation of ongoing staff development education in cultural competency.

The implementation of these strategies suggests a blueprint for change and assistance to transform health care organizations to respect the cultural values and beliefs of patients and staff. To do so, fosters health care organizations that are self-reflective and committed to improving cultural competence in the reduction of health disparities among racial and ethnic consumers in the American health care system.

Cultural competency education and training. Cultural competency education and training are accomplished through staff participation in workshops, seminars, and presentations regularly offered by healthcare organizations. The outcome of the training sessions should yield practitioners being able to adapt to the needs and preferences of the consumer and their cultural identity (Jackson, 2015). In a meta-analysis, Jackson (2015) contrasted the viewpoints of the evidence-based practice literature and the cultural competence literature via: (a) the framework s addressing interrelated factors in

treatment; (b) an in-depth examination of the practitioner qualities related to organizational context; (c) and lastly recommendations to create, sustain, and implement culturally responsive behavior health interactions.

Jackson (2015) suggested cultural competency training should not only address cultural differences but pay attention to the user's societal factors such as racism, sexism, heterosexism, ageism, and the impact these social determinants have on mental health and mental illness. Jackson (2015) further proposed that clinician training in cultural competence places an emphasis on paying extra attention during the development of the self- assessment, building cultural knowledge, establishing cross-cultural communication skills, and working to address attitudinal barriers such as bias and stereotypes (Jackson, 2015). Clement et al. (2015) advised any curriculum intended to enhance cultural competence in providers needs to incorporate understanding regarding language, folk illness, and treatments, as it pertains to culturally responsive mental health treatment and provider practice.

In general, cultural competency training uses cognitive approaches intended to transfer knowledge, but unfortunately, have been criticized for lacking rigor and participation in the learning process (Aggarwal et al., 2016b). Utilizing a mixed-methods methodology, Aggarwal et al. (2016b) queried 75 clinicians worldwide on their training preferences in cultural competency and their reasons. Additionally, the researchers explored the relationships between patients' and clinicians' characteristics with instructional method preferences.

According to Aggarwal et al. (2016c), best practices in cultural competence training methods are of value in mental health due to the lack of regulatory standards in psychotherapy interventions. The researchers theorized clinician adherence and aptitude in impactful verbal interactions encompassed cultural competence training components, which included a review of written guidelines, case-based behavioral simulations, and the supervision of cases (Aggarwal et al., 2016c). The study also advised that less interactive methods such as reading instructions or watching videos are described as being least impactful in changing clinicians' behaviors. The authors' results indicated clinicians preferred case-based simulations over videos for training methods (Aggarwal et al., 2016c). The results of this study are paramount and will be of value due to the study's contributions to research on cultural competence training in behavioral health and in providing clinicians' learning preferences in the development of future cultural competency training.

Limitations of cultural competency training. Training models in cultural competency, although essential for organization and training institutions, have been criticized for lacking association with theory by being constructed with a presumption of human traits rather than with an ideological construct. Jongen et al. (2018) offered limitations to cultural competence in health workforces, which indicated many cultural competency training interventions are generic and do not target specific skills and knowledge or types of care relationships that exist in health care. Aggarwal et al. (2016b) warned changes in clinicians' knowledge, attitudes, and skills actually will not change unless there are institutional structure changes in the delivery of health care. Although

multiple indicators contribute to disparities in health care, research evidence exists that identifies bias or stereotyping on the part of the health care provider as a factor in contributing to differences in the delivery of health care (DelVecchio Good & Hannah, 2015; Jernigan et al., 2016). The critical analysis of this body of literature justifies the importance of medical training in cultural competency. The investigation of the study site's psychiatric residents will build upon previous research and investigate their perceptions of the residents to provide an understanding of the context and boundaries of their cultural competency training to deliver culturally appropriate mental health services to their patients.

Implications

As illustrated in the review of the literature, cultural-competency training in medical education is understood as a necessity for mental health providers engaging with diverse clients in a multicultural environment, mainly working with individuals living with mental illness (Jackson, 2015). The reviewed literature suggests the emergence of cultural competency medical training as a strategy used to manage the challenges of providing better patient-provider engagement, meaningfulness, and wellness for mental health treatment among culturally diverse populations.

The implications of this study provide insight into the formalized, cultural-competency, medical education of third and four -year psychiatric residents and their learning experiences which influence transcultural self-efficacy and transcultural skills development. Through this qualitative case study, the investigator learned the residents' perceptions of their cultural competency training and gained an understanding of changes

needed to more efficiently engage their culturally diverse patients, families, and the community at the study site. The data collected data in this study were used to improve and develop an intensive training module in cultural competency for psychiatric residents. The project study not only provides recommendations for modification, improvement, and development but served as a plan for the evaluation of future psychiatric residents' perspectives for training in cultural competency.

Summary

Educational initiatives intended to reduce health disparities through cultural competency training will not only enhance the traditional pedagogical practices but include and cultivate a new and highly developed approach to convey complex implications of culture and cultural differences. Hence, the objectives of medical education training must be to train more sensitive clinicians whose long-term goals are to improve the health disparities that exist among the ethnically changing psychiatric population.

The racial differences among patients and providers are contributing factors that continue to plague health care disparities in the United States. To address diversity, medical schools have included cultural competency training, which is discussed either minimally or embedded in the clinical contexts that medical residents have difficulty identifying. This type of training leaves clinicians feeling uncomfortable in transferring the material, making it difficult to provide consistent culturally sensitive clinical experiences to their patients.

The inquiry of the CHNA 2013 identified a concern among stakeholders, patients, and practitioners with the delivery of culturally appropriate mental health care related to its culturally diverse patient population at the study site. The CHNA 2016 inquiry not only unveiled concerns with the provision of culturally competent health care but also in the medical training in cultural competency. The 2019 CHNA snapshot of the community revealed the serviced patient population spoke a language other than English at home, taking into account the cultural difference between patient and health provider as stated on the study's website,. In 2019, the CHNA continued to identify the daily challenges that affected community residents' physical and mental health. A review of the literature provided a critical examination of the delivery of culturally competent health care, its relation to medical education in cultural competency, and what is needed to deliver efficient, culturally responsive mental health care to a diverse patient population.

I specifically investigated the nature of the problem of cultural differences between providers and patients and possible solutions through the perceptions of psychiatric residents' cultural competency training at the study site. This qualitative case study examined the residents' perceptions of their cultural competency training in the delivery of culturally appropriate mental health care. The application of a qualitative research design was used to uncover a greater understanding and interpretation of the residents' perceptions of their experiences in the study site's cultural competency medical training . The implementation of this design methodology identified and described the participants, named and defined the data collection instruments, and developed interconnecting themes in the data analysis to illustrate the findings and report responses

to the research questions. In Section 2, I will discuss data collection and analysis to understand the perceptions of the psychiatric residents in their cultural competency training and the proposed project. In Section 3, the presentation of the project will be discussed in detail, outlining the components, timeline, activities, and methods of the project. Lastly, Section 4 contains the discussion of the project strengths and limitations, alternative approaches, and reflections learned in the development of the project study.

Section 2: The Methodology

Introduction

Integrating cultural competency training in education can contribute to better patient–provider engagement, meaningfulness, and mental health treatment among culturally diverse populations. Cultural competency describes a variety of interventions developed to improve accessibility and effectiveness of health care services for people from different racial and ethnic backgrounds. The implementation of cultural competency training addresses cultural and linguistic barriers existing between healthcare providers and patients, affecting the quality of healthcare delivery (Govere & Govere, 2016). Characteristics of cultural competency include employing health care practitioners who are ethnically or socially similar to the population they serve. Therefore, the focus of this study was the cultural competency training experiences of residents to help identify ways to improve training at the study site.

Research Design and Approach

A qualitative case study design is an in-depth analysis of a bounded system (Creswell, 2012). Further, through a collective case study research design, the researcher describes and compares multiple cases to provide insight into the issue (Creswell, 2012). With this research design, the focus was on a selected group of psychiatric residents who participated in cultural competency training in their residency training program. I chose a case study design to learn about the residents' perceptions through discovery and interpretation rather than hypothesis testing. By concentrating on this single phenomenon, I uncovered the opinions of eight psychiatric residents regarding cultural competency

training by focusing on holistic descriptions and explanations. The strength of a case study is also the examination of a variety of evidence in a real-life context (Creswell, 2012). The data collection procedures involved three sources of evidence that included focus groups, transcripts, and review of previous training curriculum. Applying a case study design allowed the participants to talk about their individual experiences in a small group setting. I collected third- and fourth-year residents' individual experiences, their understanding of cultural competency training, and the effectiveness of the training in the treatment of their culturally diverse patient population. Thus, by using a collective case study design, I was able to develop a detailed description of the training experiences of the residents.

Alternative research designs were considered such as an ethnographic design; however, an ethnographic design is focused on how people create and understand their daily lives to investigate how interactions are influenced by the larger society (Creswell, 2012). Alternatively, the case study design supported an understanding of the psychiatric residents' perceptions of their training rather than the larger society, limiting the use of an ethnographic design.

Further, a quantitative research study tests scientific theories by examining the relationship among variables that can be measured and analyzed using statistical procedures (Creswell, 2012). Quantitative approaches test and verify theories; however, it would not have been beneficial to collect the residents' perspectives of their training in cultural competency training or be able to highlight personal values in this case study. Therefore, the implementation of a qualitative case study research design was the most

appropriate to address the problem and research questions of this study. The application of this case study project design was used to directly deliver beneficial information to the study site's psychiatric residency program regarding its cultural competency training in the delivery of culturally sensitive mental health care.

Participants

Purposeful sampling is a procedure where the researcher chooses the subjects to include in the study to test emerging themes and to understand the central phenomenon (Creswell, 2012). The purposeful sampling methodology related to the purpose of the research and helped me understand the problem and address the research questions. This qualitative case study investigation involved homogeneous sampling to learn more about the effectiveness of the cultural competency training for psychiatric residents who participated in cultural competency training at the study site. Using this sampling method, I intentionally selected third- and fourth-year residents who completed the training session on cultural competency, thus selecting information-rich cases allowing for an in-depth case study. Additionally, I ensured that the different perspectives of the culturally diverse psychiatric residents were captured by using a maximal variation sampling, which allowed for representation of the whole third- and fourth-year class of the psychiatry residents at the study site. The sample was chosen before data collection began from a 2016-2017 academic school year list of third- and fourth-year residents.

Access to participants was obtained through the residency training administration. To recruit participants for the focus group, I was granted permission from the residency director to introduce the study to psychiatry residents at the study site. During a 30-

minute information session, I presented the rationale for and methodology of the research study to both third-year and fourth-year psychiatric residents. Through the introduction and solicitation letter, all residents were made aware of the voluntary nature of the study; those interested in participating in the focus group were directed to contact me by telephone or by e-mail. Of the 12 identified psychiatric residents, all 12 met the eligibility requirements. Due to staffing schedules and annual leaves, the focus group size was reduced to eight eligible residents comprised of three third-year residents and five fourth-year residents. The difference in training level was not taken into consideration.

Various demographic data were collected from the focus group sample. The three third-year residents included two females and one male, and the five fourth-year residents included two males and three females. The participants self-identified as Asian, African American, and Latino. The participants all described their primary language as English; however, each participant spoke various secondary languages: Urdu (Pakistan), Punjabi (Pakistan), Spanish (Dominican Republic), and Yoruba (Nigeria). According to residency program documents, all residents were classified as international medical school graduates. Further, the results of the demographic survey (See Appendix B) indicated the age ranges for participants fell in two categories: between 30-39 years of age (five participants; three female and two male) and between 40-49 years of age (three participants; two female and one male).

The 60-minute focus group session was carried out with the same identified third- and fourth-year residents at a time most appropriate for all. Through a collaboration with the residency training director, I obtained a suitable interview site that was spacious, well

ventilated, and accessible to the residents. This collaboration also yielded access to the psychiatric residents' schedules, demographics, and any other items needed to conduct the interview with the least interruption to clinical services. The focus group discussion allowed one participant's comment to feed off another comment, and so on. The residents were able to dig deep into their perceptions of their cultural competency training. Developing a researcher–participant relationship also assisted me in identifying and valuing participants' likes and dislikes, their values, and their nonverbal language. Light refreshments were served as an incentive for participation.

Due to my past relationship, familiarity, and employment at the study site, access to study materials and participants was obtained following the study site's Institutional Review Board (IRB) approval process. The IRB approval was obtained before the start of the study (approval number 09-08-17-0298911). I complied with the IRB regulations at the study site and Walden University to protect the rights of the resident participants. Securing IRB approval from study site required a full description of the research to be disclosed, which included the research procedures and the means to protect the subjects' confidentiality. The IRB at the study site reviewed the methods described in the proposal to ensure all ethical considerations were addressed and all research actions were disclosed. The study site's IRB received a copy of the informed consent forms and an explanation that outlined strategies to securely store them. Both the IRB at Walden University and the study site received a copy of interview questions for examination to determine the sensitivity of each question. Finally, the IRB at both institutions received

assurance that the informants' responses would be used to only report the information aligned with the subject of this study.

The identified and selected third- and fourth-year residents provided consent to participate in the data collection process. I maintained the confidentiality of the information collected from participants. Although absolute confidentiality is not possible with a focus group, I reminded the participants of the need for confidentiality at the beginning of the group session. Through numeric assigned codes, every effort was made to prevent anyone from outside the project from connecting individual participants with their responses.

Data Collection

Qualitative research methods are concerned with gathering a comprehensive understanding of the phenomenon centering on the *how* and *why* of the issue under study (Boddy, 2016). A sample size with a minimum of one is adequate for qualitative research (Boddy, 2016). Utilizing this assumption, I used a sample of eight of the 12 third- and fourth-year residents who participated in the cultural competency training sessions.

Gaining Access to the Participants

Access to the participants was obtained through the permission of the residency director. A focus group interview was used to gather descriptive data, in the words of the residents, enabling me to develop an insight into their perspectives of the study site's residency cultural competency training. The similarity of the group members justified the use of a focus group discussion. The focus group included a moderator, a recorder, and the eight psychiatric residents. The advantage of conducting a focus group was the

interaction among the group participants. A disadvantage of using a focus group is participants succumbing to peer-pressure when answering questions among their peers. However, for this research, the focus group was beneficial in obtaining responses from the residents more quickly than interviewing them separately, allowing me to control the type of information received and ask questions that probed more deeply.

One focus group meeting was held within three weeks from the date of the information session at which I first presented. For the convenience and comfort of participants, the focus group was held at the study site's residents' library. The participants were provided light refreshments along with copies of the consent form and a demographic data form. Seating was arranged in a circular configuration to allow for face-to-face interaction between me and participants and to allow an unobstructed view of all participants. Participants who arrived promptly were asked to complete and sign informed consent forms, demographic data forms, and return the completed forms. The focus group interviews took place on January 18, 2018 from 4:00 p.m. to 5:15 p.m.

Keeping Track of the Data

The data collection in this qualitative case study occurred through an audio-taped focus group and document review. The focus group methodology was used to collect a shared understanding and accurate view of the residents' cultural competency training from their perspectives. The interaction within the focus group helped to solicit data collection from multiple participants and observe and record group dynamics and interactions among the group. The interview consisted of general, open-ended questions to engage participants, which provided depth, the richness of topic, and observation of

nonverbal behaviors. Further, an interview protocol (See Appendix C) was formulated and used to structure the focus group discussion and note-taking. The advantages of using a focus group with the residents included (a) eliciting views and opinions from each participant; (b) collecting data from multiple participants; and (c) observing and recording the interactions and group dynamics that unfolded among the residents.

With the permission of the group participants, the data collection process included the audiotaping of the group interview to ensure the precise and accurate compilation of the member's verbatim responses. Through a note-taker, interview notes were also recorded on participants' nonverbal perceptions and impressions to ensure the investigator did not miss information. As the moderator, I recorded observational notes, which included observations from individuals who appeared to be disengaged in the discussion, concerned with the time, or seemed uncertain at times. I noted that several of the participants were more vocal, whereas others used more body language to indicate agreement with the statements of others.

I was mindful of issues and biases that might arise in using this data collection method such as (a) my presence causing biased responses; (b) group responses being dominated by one or two people in the session; and (c) the participants' reluctance in sharing their real feelings toward the training program. Care was taken to reduce the likelihood of bias and confounding factors. I began the interview session by providing a professional introduction to build rapport among myself and the participants. Group norms and expectations for the discussion format and interactions between those involved

were established to ensure comfort and confidentiality in sharing information and personal experiences. During the focus group interview, many of the participants appeared to be enthusiastic about their participation in the study. However, some of the participants were more vocal than others during the conversation. On occasion, I had to engage several residents by repeating the question and addressing each of them directly.

The explanatory notes on behaviors (verbal and nonverbal reactions) allowed me to monitor the data collection process and analyze the collected data. The data were stored in labeled, locked file folders in a password-protected computer file to keep the interview organized. A matrix was used to sort and organize the data. A research log was utilized to organize research information categorized by source and type of information. Reflective journals assisted in recording and examining personal assumptions and individual beliefs to assist in understanding emerging themes and identifying participants' belief systems.

A document review of the training curriculum was also conducted to gain knowledge of the current cultural competency training materials. The review indicated that cultural competency training begins with a computerized general training of medical scenarios for all study site medical residents not only inclusive to those in the psychiatry residency training program. Introduction to cultural competency training is initiated through *A Physician's Practical Guide to Culturally Competent Care* developed by the United States Department of Health and Human Services Office of Minority Health (n.d.); however, the cultural formulation is taught only to the psychiatry residents through two web-based modules. Cross-cultural psychiatry is included in the third-year

curriculum as a two-session module. Topics introduced in cross-cultural psychiatry training included the impact of language on evaluation and treatment, culture-specific syndromes, folk belief systems, and other issues that reflect the effect of culture on one's identity and psychiatric illness.

The Role of the Researcher

Former administrative roles and relationships provided me access to the residency director, psychiatric residents, and space to conduct the study. The demographic and background data of the psychiatric residents was obtained through permission from the director of the Department of Psychiatry and the assistance of the residency director. Class rosters containing the residents' demographics, class status, and training materials were accessed from the Psychiatric residency director. Research bias was limited due to my relocation to an affiliate health facility, therefore, restricting prior knowledge and access to the current and targeted residents for the study.

Data Analysis

Data analysis is a methodical search that results in a reduction of the data within the parameters of the inquiry (Mayer, 2015). The primary objective of data reduction is to diminish information without losing data (Mayer, 2015). The reduction of data began with editing and summarizing the residents' conversations, coding and documenting the data, followed by conceptualizing and explaining to give meaning to the data.

The recordings of the conversations with the third-year and fourth-year psychiatric residents formed the basis of this data analysis. The recording of the focus

group was sent to an outside transcription company, Rev.com, for accurate and professional transcription. The data analysis involved making sense of the text, providing interpretation, and identifying the significant meaning of the collected data. Throughout the analysis and interpretation of the data, I sought to gain an understanding of each participants' perception of their cultural competency training in the delivery of mental healthcare at the study site.

The strategy of data analysis begins with preparing and organizing the data, then reducing the information into themes through a process of coding (Creswell, 2009). Creswell (2009) identified three essential steps in data analysis that involves: (a) reducing data into meaningful segments; (b) assigning descriptive identifiers for segments;, and (c) combining codes into broad descriptions or themes. My preparation for analysis of the data involved editing and summarizing the transcript completed by Rev.com and highlighting the conversations to identify recurring concepts and themes. The respondents' ideas were highlighted in pink and blue to identify female respondent responses and male respondent responses, respectively. Notes made in the margin of the transcript helped to generalize thoughts about the data and to reduce data into segments.

Descriptive identifiers, such as "D" for definitions, were underlined and highlighted in the margins to develop meaningful segments. While the initial analysis of the transcript began with Creswell's strategy, the advanced analysis of data included the utilization of ATLAS.ti, a computer software program, to organize, sort, and track the collected data and develop the themes. Although a computer-assisted model was used, I developed a deeper meaning of patterns and relationships when developing the codes and

when developing sub-categories, which led to the overarching themes from the focus group.

The utilization of the ATLAS.ti method of analysis assisted me with storing and organizing the data to assign labels and codes. The use of computer software facilitated searching through the data to locate specific text and words. The software helped with visualizing the data to be used in the presentation of the findings of the study. The use of the ATLAS. ti database validated the creditability of the case study, as it provided me with the ability to track and organize data sources. Through this program, notes, narratives, and audio files were stored in a database for easy retrieval for later analysis. Data tracking was also achieved and managed through written notes from the interviews and a reflective journal completed by the researcher. In the journal notes, I reflected on developing an understanding of the conversations, including reminders about the surroundings, disruptions, and attitudes of the participants, which led to additional discoveries.

Creditability and Dependability

The goal of qualitative research is to provide an in-depth understanding of the target population. The criteria for evaluating this qualitative case study focused on how well I have provided an accurate, descriptive analysis of the situation and persons studied. Triangulation enhanced the credibility of the study. Triangulation confirmed the data and ensured the collected data was complete.

Triangulation

Triangulation provides confirmation and is the process of corroborating evidence from different individuals, data, or methods of data collection (Creswell, 2012). Noble and Heale (2019) described triangulation as method used to increase credibility. According to Nobel and Heale (2019), the use of multiple data collection sources provides a convincing and accurate explanation of the study, and triangulation ensures an in-depth and unbiased set of results.

Triangulation was applied in this study and involved the careful review of various methods of data collection in achieving a more precise and practical understanding of the phenomenon under investigation. Applying triangulation to the data collected via the focus group interviews, documents, and field notes helped to provide a clearer picture of the residents' perceptions of their cultural competency training. The triangulation of the field notes, documents, and recorded notes provided an audit trail of the documentation used in the study.

Member checking. The study followed specific procedures to address the accuracy of the data. The transcripts from the focus group interviews were emailed to the participants for individual accuracy review, and an optional review session was offered to allow participants an additional opportunity to review their statements for accuracy. Member-checking of the data supported the qualitative credibility of this study, as the process allowed the participants to read and review the transcripts of the interviews for the accuracy of the findings. I made myself available to any participant who desired one-

on- one clarification and correction of statements made during the focus group. However, none of the participants chose to do so.

Peer-debriefing. In addition to member-checking and the triangulation of the data for accuracy, colleagues from the medical center conducted a peer debriefing following the preparation of the transcripts. The peer debriefing was conducted via face to face discussions and assisted in the review of the researcher's interpretation of the focus group transcripts. Their assistance and feedback were sought to evaluate for the accuracy and credibility of the identified themes. The peer debriefing provided clarification on department-specific terminology, timeframes, and practices discussed during the focus group. I invited an independent researcher with previous experience and a doctorate degree who was not involved in the data collection process to conduct an external audit to ensure there was alignment between the data and identified theme(s) to control for researcher biases and to provide an objective assessment of the project.

Discrepant cases. There were no discrepant cases noted in the analysis of the data.

Data Analysis Results

Qualitative case study methodology provides tools for researchers to study complex phenomena within their contexts (Creswell, 2009). Applying a qualitative approach is a valuable method for health science research to develop theories, evaluate programs, and cultivate interventions. This qualitative case study was an exploration of cultural competency education within a psychiatric residency training program using the in-person interviews of psychiatric residents as a data source. The application of this

methodology, in the context of a focus group, with eight psychiatric residents ensured that the issue of medical training in cultural competency was not explored through a singular perspective but through a variety of perspectives. The focus group met once, and the data were recorded both by a note taker, me and an audio recorder. The variation in views allowed multiple aspects of the phenomenon of culturally responsive training in medical practice to be revealed and better understood.

Clark and Braun (2017) explained themes are used to interpret meanings of patterns within the qualitative data. From the recorded and professionally transcribed focus group notes, I was able to identify themes across participants' responses. The transcript of the interview revealed data that suggested shared experiences among the psychiatric residents participating in cultural competency training in the study site's residency program. The research questions guiding this study and revealing shared themes were:

RQ1: How do psychiatry residents perceive the impact of their cultural competency training in the delivery of culturally appropriate mental healthcare?

RQ2: How do psychiatry residents perceive the value of cultural competency training in the provision of culturally sensitive mental healthcare?

RQ3: How do psychiatry residents perceive their current medical training in cultural competency about their careers in culturally different communities?

Discussion of Themes

Through the use of the analytics program, I identified approximately 75 keywords at the start of the analysis. The words included the following open codes: cultural,

competency, background, history, family, education, advancement, culture, quality care, mental health, community nationality, types, training, improvement, timing, language, problems, language barriers, limitations, psychiatry, mental health, lectures, classrooms, interpretation, orientation, content, games, adequate, advantages, and disadvantages. With the assistance of the ATLAS.ti computer software, the keywords were then collapsed into axial codes labeled as cultural competency, background, knowledge, learning style, training format, language interpretation, interpretation techniques, the importance of culture, training content, training timing, similarities in cultures, best practices, and learning preferences. Three significant themes emerged from the codes which were: (a) definitions of cultural competency; (b) training practices and preferences; and (c) culture. These themes emerged from identified patterns in the data and the psychiatric residents' recurring statements.

Theme 1: Definitions of cultural competency. Teaching cultural competence is an educational prerequisite for medical schools in meeting accreditation requirements (ACGME, 2013). The emergence of this theme was derived from the keywords "culture" and "cultural history" and the axial code labeled as "cultural competency." The identification of what culture and cultural competency is became evident in the residents' discussion, description, and understanding of their perceptions of those key words. Resident 1 defined cultural competency as "helpful in understanding the person's background and helpful knowledge to provide good, competent care specific to that culture." Resident 2 added, "Positive mental health outcomes in treatment depend on an understanding of our patients' cultural background."

The psychiatric residents understood cultural competency to be an understanding of the patient's culture so that care could be provided in a manner that not only met the medical need but also acknowledged and honored the patient's moral and cultural beliefs. Psychiatric residents also understood that cultural competency training is necessary for residents to enable them with understanding their patients' cultural backgrounds and to align them with psychiatric best practices and knowledge to provide better treatment and increased positive health outcomes. The residents' understanding of cultural competency set the foundation for the residents' expectations of their cultural competency training.

Theme 2: Implementation of cultural competency training. This theme emerged from such words as "training," "education," and "learned skills," which developed into the codes labeled as "competency," "training," "timing," and "differences" (See Table 1).

Table 1

Themes Regarding Cultural Competency Training

Theme	Code	Representative quote
Cultural Competency Training	Timing	I think it (cultural competency training) would increase our comfort level. So, it's nice to start from the beginning rather than six months into residency training
	Training preferences	Computer-based training because of the flexibility of this learning technology
Language Differences	Interpreter services	Interpreter service is that of convenience and expressed the simplicity of applying it is a "call, and then they connect you with any of the languages that the patient speaks."
Cultural Differences	Benefits of cultural similarities	Sharing their patients' ethnicity as "an added advantage, because they connect more easily to you" and "the patient who is coming from… my country, they like to see us."
	Barriers to cultural differences	"When it comes to Cyracom, interpreters cannot really interpret emotion."

The residents reported the implementation and the timing of their cultural competency training made a difference in improving their comfort-level in delivering culturally sensitive psychiatric care. The lack of medical training in cultural competency is associated with health disparities, cultural and language barriers, biases, and prejudices between patients and providers (Govere & Govere, 2016). Resident 2 commented, "I think it would increase our comfort level. So, it's nice to start from the beginning rather than six months into it." Several residents expressed receiving training before the start of residency training (during orientation), before being introduced to their patient population. Resident 2 expressed, "Actually, when I think I got the training, I got it before I even started my orientation. Before the training started, that is much better." Resident 4 experienced different timing of the training, and he wanted to see the start of cultural competency training occur at the same point in training for all. He described his experience and reported:

> So, my cohorts, we didn't get it before our training starting. We got it like, in between our rotation. So, you have to make up sometimes. We are open that going forward, uniform, so everybody will get the training before residency training because you don't know when you admit the patient that you need to exercise that knowledge. And if you don't have the training, you might not be able to address the patients' issue, culturally the way it should be.

Resident 4 suggested improvement, "So, what I'm trying to say is that if it could be uniform."

Resident 1 summarized:

> So, I think that it can be improved further, especially for the newcomers in the first year. I know we get it through the year, but it's like scattered all over the year. Initially, a couple of months, you're not getting a lecture or orientation on most of that stuff. Maybe incorporate it into the earlier part of the year, when the new classes are coming in. That might be helpful.

Importance of on the job training. The residents' perception of their cultural competency training suggested they would not change the teaching methodology, and that they believed the length of the training to be adequate. The residents' perceptions of the training suggested, "The training is divided well into six weeks…every topic is separated, and it's not all jumbled together".

Resident 2 reported:

> Every day, every patient we meet we're learning from" and "even though we're taking the formal training, I think we're learning on the job. So, every day we'll learn something, a new patient comes in from another culture we're learning from them.

From this response, I was able to identify a theme of adequate preparation to provide adequate, culturally responsive care to patients.

Training practices and preferences. Codes such as "learning" and "best practices" led to the emergence of "training preferences" as a theme. The endorsement of cultural competency training in mental health providers has led to the development of diverse methods of providing cultural competency training and learning opportunities.

The residents' perceptions of their current cultural competency training indicated approval of their computer-based educational technology. An endorsement for the educational technology came from Resident 2, who expressed satisfaction with the computer-based training due to the flexibility of this learning technology. Resident 2 expressed that "you go at your own pace, and you can stop, rewind, and go forward if you want. You can review the videos over and over if there's something that you missed". Resident 7 also approved of the current training methods stating, "Yeah, I think the computer-based method is good. And it is like a game in the form of a lecture. But as they mentioned, computer-based, we can do at our own pace."

Benefits of training scenarios. Computer-based applications are increasingly used to support the training of medical professionals (Barsom, Graafland, & Schijven, 2016). The use of simulation training in medical schools covers the range of difficulty from simple reproduction of isolated body parts to complex human interactions portrayed by simulated patients (Barsom et al., 2016). The computer-based training in the study site's cultural competency program is designed for general medical practice, but it addresses mental health training in various scenarios.

The residents discussed the scenarios, which specifically reviewed delivery of mental healthcare services. Resident 3 addressed the content of a specific learning vignette as it related to "instruction of medication" and the "misinterpretation of the dose." She elaborated on the scenario which introduced "language barriers and the importance of the delivery of medical care in the first language of the patient to improve the quality of care to prevent medical errors." She reported in this particular scenario:

> The patient was a Hispanic patient and was given the instruction of medication…the patient kind of misinterpreted the dose…because I think in Spanish, once means something else than in English, it means something else. So, the mom was giving the childlike extra pills until the language was clarified when they came back to the clinic.

Culture and sexual identity. The residents also shared that their cultural competency curriculum encompassed several components which addressed traditional ethnic and racial cultures, but also discussed gender identity as a culture. Resident 2 shared, "We have extended classes in human sexuality that addresses transgender issues, LGBT issues, and hospital-wide training, in the Department of Psychiatry, so it's pretty extensive." Resident 2 also pointed out that, "The human sexuality course is at Columbia University, and it's delivered in multiple parts, six weeks. Six courses that talk about all of it." It is the perception of the residents that the cultural competency training is not only inclusive but extensive in design.

Resident 2 shared "we also have lectures in cultural psychiatry, which explains different cultures and stereotypes and diagnoses and other cultures." Resident 1 added, "There is a cultural competency training online course, which is almost like three to four hours of course where you have to do it every year." Resident 1 continued, "Then we have PeopleSoft software for all staff (competency training) which has culture competency courses, you also have to do annually." Resident 2 indicated "different lectures, at least three lectures in a year, which are based on cultural competency, and different kinds of social and cultural issues related to our field." This resident believed

the “cultural competency training aids us in how to ask questions appropriately so that we’re comfortable, and our patients are comfortable.”

Theme 3: Interpreter services as a cultural bridge. In the formulation of this theme, codes such as “language,” “language barriers,” “cultural differences,” and “tools” developed this theme and an understanding of the cultural differences between residents and the population they serve. Interpreter services are needed in the delivery of mental healthcare to a culturally diverse patient population**.** Developing a therapeutic alliance in delivering quality mental healthcare is essential to the residents. However, the group participants voiced concerns about the services available. Resident 6 discussed the inaccuracy of translated dialogue and stated, “The problem with the Cyracom (a third party, phone-based interpreter) is that sometimes they do not give the exact information. And sometimes probably it’s not 100%, the information that the doctor is trying to provide.” However, Resident 3 expressed the simplicity of use and the convenience of the interpreter service, stating that it is a “call, and then they connect you with any of the languages that the patient speaks.”

Not previously mentioned, Resident 7 expressed that the use of this language interpretive service diminished the emotional connection needed between provider and patient in the delivery of quality mental healthcare, “When it comes to Cyracom, they cannot interpret emotion. When the patient is like tearful, or ... they (interpreter) aren't seeing the patient. So, they were just hearing the patient. So that's always a challenge.” The residents’ perception of the Cyracom interpreter services, introduced in their cultural competency training, serves both as a benefit in delivering culturally sensitive mental

healthcare, but also as interference in building a therapeutic alliance. Becher and Wieling (2015) conveyed the negative aspects of using interpreters as not only about language interpretation but the absence of cultural expression and/ or beliefs about the clinician, thus impacting the development of the therapeutic alliance between a limited English proficiency (LEP) patient and their provider.

Use of live interpreters. In addition to the Cyracom devices, the residents reported there are also live interpreters available to assist with delivering mental healthcare in the preferred language of their patients with LEP. Live interpreters aid in reducing the language barriers that exist among patients with LEP (Becher & Wieling, 2015). In their cultural competency training, residents are taught to use the available language services to communicate with their culturally diverse patients in the most appropriate way. The residents' experiences in the use of live interpreters are both beneficial and burdensome. Resident 5 shared that the availability of live interpreters is limited, and they are "restricted to only specific languages… such as Spanish …and are available during daytime hours only" and not available on a 24-hour basis comparable to the hours of operation of the study site's hospital."

The benefits of using live interpreters aid in building an alliance of trust between patients and healthcare providers (Becher & Wieling, 2015). Resident 4 shared an experience with using a live Spanish interpreter and reported, "I noticed patients prefer having a live Spanish interpreter to talk to them. They can relate their beliefs, unlike using a Spanish Cyracom interpreter." However, the resident also voiced concerns about using a live interpreter and shared concerns about the reliability of the interpreters'

translations. An expressed concern of the residents referenced content of the conversation, and whether the interpreters are conveying all of the information which is spoken to them by the patient. Resident 4 shared a patient experience in which a patient met the live Spanish interpreter and immediately built an alliance through language and began a conversation, "They would speak in Spanish to the patient, and the interpreter would not tell us what they told him."

Building a therapeutic alliance begins at the first visit, and if conversations are shared between patient and interpreter, and not shared with the practitioner, a therapeutic divide may occur (Becher & Wieling, 2015). Resident 4 discussed the importance of the conversation in the meeting, "It might not be treatment-related, but it might be something about their family that really impacted them that might actually help in the treatment plan." In their cultural competency training, the residents are taught about the use of language interpretation to reduce language barriers that may exist between them and their patients. Their concern in the use of live interpreters suggests advocating for building an improved professional relationship in their cultural competency training that will shape a collaborative partnership with the interpreters in the delivery of mental healthcare with their patients.

Theme 4: Cultural similarities. In this study, the sub-question asked, "How do psychiatry residents perceive their current medical training in cultural competency concerning their careers in culturally different communities?" The residents' opinions suggested sharing similar cultures is beneficial in the delivery of care to a diverse population and what attracted them to this residency training program. Although

differences exist between the residents and the study site's patient population, the similarities outweighed the differences. Resident 3 suggested a benefit of sharing their patients' ethnicity as "an added advantage because they connect more easily to you, and the patient who is coming from… my country, they like to see us."

Njeru et al. (2016) suggested that optimizing the utilization of mental health outcomes would require addressing LEP. Maximizing healthcare among LEP patients, requires incorporating elements that have been shown to improve healthcare access, such as community engagement and incorporating language-congruent community health workers. Doing so would enhance cultural competency and responsiveness within healthcare systems to help with patient engagement across the care continuum of culturally diverse patients and those who are LEP.

The residents' similarity in ethnicity and language represents an appearance of cultural congruency with their patient population. Residents reported that their own culturally diverse backgrounds help them feel connected to their diverse patient community at the study site. Resident 3 said, "When I saw that I know that the patient speaks my language, she was delighted that and I was there, she easily opened up to me." Resident 3 also reported that "you know that builds the alliance more because I speak the language."

Through their responses, I found that residents felt that the diversity of their group aided in their delivery of quality mental healthcare, in that the patients are more comfortable with practitioners of the same, or similar, cultural backgrounds. Resident 3, who is from Nigeria, shared her experience with a patient who was from Nigeria: "when

she came in and saw that I was from Nigeria, she was happy that I was there and easily opened up to me…we kind of connected very easily… and each time she comes, she asks if I am going to see her the next time." The cultural competency training serves to enhance the residents' understanding and aid in providing a connection to their patient population through their familiarity with their cultures and ethnicity. Resident 2 reported, "To have a deep understanding of the cultures of their diverse patient population assists in the delivery of culturally responsive mental healthcare."

Outcomes

The purpose of this qualitative study was to identify residents' perceptions of the cultural competency training offered in the residency training program in the delivery of culturally responsive mental healthcare. This study addressed a gap in practice regarding psychiatric residents' perceptions of their cultural competency medical training. Through a case study, utilizing a focus group interview, eight psychiatric residents in their third or fourth year of residency training provided their experiences about their perceptions of their current cultural competency training.

The data from the study were analyzed by using three guiding research questions that resulted in the following three themes: (a) definitions of cultural competency; (b) implementations of cultural competency training; and (c) interpreter service as a cultural bridge. Themes 1 and 2 addressed the research question, How do psychiatry residents perceive the impact of their cultural competency training in the delivery of culturally appropriate mental healthcare? These themes revealed that residents' overall perception of their cultural competency training was highly positive. The residents expressed

cultural competency training as being essential to the delivery of culturally responsive mental healthcare. Their perception of cultural competency training received was shown as “helpful” and “positive.”

The second research question, How do psychiatry residents perceive the value of cultural competency training in the provision of culturally sensitive mental healthcare? was also addressed in Themes 1 and 2. The residents stated that the timing of the cultural competency training was a vital component for psychiatric residents to feel comfortable in the delivery of culturally sensitive mental healthcare. While acknowledging timing as an essential part of their training, their preference for computer-based learning versus the traditional lecture format of training was evident. Their computer-based training scenarios proved useful for multisensory learning of therapeutic techniques in delivering culturally sensitive psychological healthcare.

Theme 3 addressed the research question, How do psychiatry residents perceive their current medical training in cultural competency about their careers in culturally different communities? In Theme 3, the residents identified their perceptions of interpreter services and live interpreters as a need to address their culturally diverse patient population in the delivery of culturally responsive mental healthcare. They recognized the strong relationship of language familiarity as an essential component in the delivery of culturally sensitive mental healthcare. Their cultural competency training, although extensive in instructional time, was felt to be inclusive of all cultures and gender-neutral. Finally, the residents recognized the importance of annual job training and patient experience in learning cultural competency.

Conclusion

The study examined psychiatric residents' perceptions of their cultural competency training in the delivery of culturally responsive mental healthcare for a diverse patient population. Required, in the delivery of culturally responsive mental healthcare, psychiatric residents need to participate in cultural competency training during their medical practice. The residents' perception of their cultural competency training described specific knowledge and skills necessary to promote and deliver culturally responsive mental healthcare among a diverse patient population. Residents were also able to explain the preferred training methods and rationale for their preferences, in addition to the patient and clinician characteristics conducive to their preferences and most effective for their practice.

A white paper will be used to discuss the themes extracted from the data provided by psychiatric residents. The paper will publicize findings and improvements recommended for the current cultural competency training curricula delivered to psychiatric residents in the study site's psychiatry residency training program. The white paper will be the means used to present the concerns of the current training and the suggestions from the residents for improvement to garner engagement and support from the administration at the study site. The proposed revisions to the curriculum may aid the residency training director in making targeted improvements to the cultural competency training for psychiatric residents in the future.

Section 3: The Project

Introduction

Preparing culturally responsive psychiatric residents during medical training has been identified as a necessity for the profession (Diaz et al., 2016). The responses of third- and the fourth-year psychiatric residents at the local site formed the basis for the recommendations to improve the current professional development training in cultural competency and sensitivity training. Thus, the recommendations included in the white paper are informed by the perception data provided by the residents. The recommendations are intended to capitalize on the strengths of the existing training while addressing areas of weakness and seizing opportunities for improvement to enhance residents' cultural competence further. The recommendations will be provided to the psychiatric director and residency director at the study site. The residency director will be responsible for the implementation of the current training and will be integral in executing the recommendations from the report.

Rationale

In the absence of a culturally similar healthcare workforce, as in the study site's psychiatry residency training program, cultural competency training becomes a necessity in the delivery of culturally responsive healthcare. This doctoral study was organized to understand psychiatric residents' perceptions of participation in cultural competency training. The intended outcome of this study was to discover whether the current cultural competency training provided adequate training for the residents to deliver culturally competent mental health care to their diverse patient population.

A key finding was the residents' perception of cultural competency training and how it influenced their clinical practice and the delivery of mental health care. Cultural competency is a needed service, which should be a multifaceted intervention to improve the quality of care of culturally and ethnically diverse populations (Jorgen et al. 2018). This importance was recognized by Resident 1, who said that cultural competency is "helpful in understanding the person's background and helpful knowledge to provide good, competent care specific to that culture." Resident 2 added, "Positive mental health outcomes in treatment depend on an understanding of our patients' cultural background." The residents' overall perception of their cultural competency training based on the data analysis emphasized the training as "essential to the delivery of culturally responsive mental healthcare." Their perception of cultural competency training was expressed as "helpful" and "positive." The residents also detailed the implementation of cultural competency training as a significant component for psychiatric residents to "feel comfortable in the delivery of culturally sensitive mental healthcare." Although the residents expressed preparedness and skills in caring for culturally diverse patients, some still felt inadequately prepared in cross-cultural care.

Tailoring care to meet the cultural needs of patients is challenging; however, it is a necessary practice, and medical training should reflect a more specific and targeted training as a fundamental component of cultural competency training (Green et al., 2017). The results of this study indicated that the existing training has many strengths. Future residents' participation in the training would benefit from additions and enhancements such as: (a) a more enhanced integration of the impact of culture on the delivery of

culturally responsive mental healthcare; (b) the inclusion of training for patients with LEP; (c) the involvement of religious leaders; and (d) the development of an evaluative process to measure the residents' ability to deliver culturally competent care. The literature review supplements the data gathered during the study to support these recommendations. The highlights of my findings will be reported to the residency training director and the director of psychiatry to effectively support the suggested program enhancements that build on the current training and to support new psychiatric residents in the delivery of culturally responsive mental healthcare. My feedback highlights the recommendations of the residents to augment and improve the existing residency training in cultural competency.

Transfer of Information

The outcome of the research provided in the written report, known as a white paper, will include the features of a traditional research report as well as recommendations stemming from the study's findings. A research report is a completed study that reports an investigation or exploration of a problem, identifies questions to be addressed, and includes data collected, analyzed, and interpreted by the researcher (Creswell, 2012). A white paper was chosen to address the audience consisting of policymakers, the director of psychiatry, and the residency training director.

For the study and recommendations to be meaningful for my audience, it will require a simple method of transferring of the information. Additionally, it is important to consider how a reader can make meaning from the study's findings and understand how conclusions were drawn (Crowe, Inder, & Porter, 2015). A reader should also be able to

compare the study's context with their own practice setting (Crowe et al., 2015). Therefore, I decided to use a white paper as the format for this doctoral study. The white paper will be the most effective means to disseminate the findings of my research and the recommendations when addressing the identified issues.

White papers are informational documents used to highlight or promote a product, service, or methodology, and they are used by governments, businesses, and corporations to support information and new products and to provide consumers with data. A white paper allows the reader to understand an issue, solve a problem, or make a decision (Cullen, 2018). Similarly, white papers are designed to support or advocate a solution to a problem (Purdue Writing Lab, n.d.). The white paper is a persuasive essay for the targeted audience with facts to promote an understanding of the findings, an immediate application of the results, and clarity and brevity of the outcomes in the form of recommendations.

Review of the Literature

Search Results

I conducted electronic searches of articles published within from 2015 to 2019 of peer-reviewed primary research journal articles on cultural competency training to address my research questions and the outcome of my study. My search strategy utilized several sources such as databases, Google Scholar, organizational websites, and Walden University library catalogs. Electronic databases such as Medline and PychoInfo, PubMed, and the United States National Library of Medicine were most useful.

The electronic search was conducted by first beginning with broad keywords that represented the main concepts in the research topic, including *cultural competency training*, *mental health and teaching cultural awareness*, and *teaching cultural competency*. This broad keyword search resulted in pertinent and relevant information for my study and the development of the project study. Using the advanced options on the databases allowed for the narrowing of the search by combining terms such as *teaching culture* and *health professional* or *patient-centered communication* or *(PCC)*. The inclusion criteria contained "published in English," "published 2015-2019," and "ethnic minorities." Applying the limiters function, I was able to limit the search by the date and articles with an abstract to obtain reports and information needed for the study.

Additional methods that were useful in identifying relevant articles included a search of the reference list from the key articles related to my research questions. This method also helped to locate the prominent scholars in cultural competency training by conducting an author search to determine additional information and or terms not identified in the previous electronic search. The information found was voluminous; therefore, developing an organized tracking method was useful and included categorizing related articles in sectioned binders.

Integration of Culture

Although best training practices vary in the literature, the impact of cultural factors remains central in developing successful cultural competency training interventions (Aggarwal et al., 2016; DelVecchio Good & Hannah, 2015). The training material at the time of my study was *The Facilitator's Guide: Companion to A*

Physician's Practical Guide to Culturally Competent Care, adapted from the United States Department of Health and Human Services. The objectives of the training suggested that participants should be able to: (a) identify at least five areas related to cultural and linguistic competency in medical practice; (b) identify at least three strategies to promote self-awareness about attitudes, beliefs, biases, and behaviors that may influence clinical care; (c) devise strategies to enhance skills toward the provision of care in a culturally competent clinical practice; and (d) demonstrate the advantages of the adoption of the National CLAS Standards in clinical practice (United States Department of Health and Human Services, n.d.). Additionally, according to empirical data, the understanding and acknowledgment of ethnicity, race, and culture should form the foundation of cultural competency training (DelVecchio Good & Hannah, 2015). Though dated, the training material formed the basis for my recommendation to include additional training on the impact of culture in the delivery of culturally responsive mental healthcare.

Culture is a person's values, beliefs, customs, traditions, patterns of thinking norms (Young & Guo, 2016). Learning the importance of culture in the provision of health care is at the core of cultural competency training for health care professionals (Chen et al., 2018). Conflicts between providers and patients exist when clinicians are not aware of the culture of their patient population, but cultural competency training sets the foundation to develop clinician skills they can employ to understand the values of their culturally diverse patient population. It is important for psychiatrists to learn to see patients in their cultural context and consider their cultural values and prejudices in

treating a cross-cultural patient population, keeping in mind that though psychiatrists are experts in their field, patients are experts in their experience (Scholyer-Ocak et al., 2015). Training that incorporates cultural knowledge involves knowledge of culture and race to impact psychosocial development, psychopathology, and therapeutic transactions (Sholyer-Ocak et al., 2015). The integration of cultural psychiatry can also be used for ongoing professional development, inclusive of culture and health, culture in psychopathology, and culture in clinical practice (Scholyer-Ocak et al., 2015). For health care professionals to care for a more culturally diverse population requires health organizations to incorporate some semblance of cultural competence into the curriculum and ensure that professionals possess the skills needed to apply cultural competence training effectively (Chen et al., 2018).

Currently, the residency training program at the study site does not provide instruction on culture, as evidenced in the review of the training documents. Therefore, the addition of evidence-based practices that integrate and build on cultural understanding can be beneficial to the current cultural competency training modules. The findings from the literature indicate that integrating the knowledge of culture in medical training facilitates the process to provide culturally responsive mental healthcare to a diverse patient population; therefore, the program administrators must take the lead in providing additional training in the implementation of culture into the cultural competency medical training of the psychiatric residents (DelVecchio Good & Hannah, 2015; Scholyer-Ocak et al., 2015)

Religious Involvement

For multicultural competence to result in sensitivity and respect for clients' differences, values, beliefs, and practices, the inclusion of religious and spiritual interventions is needed in cultural competency training. It is important to address religion and spirituality for culturally competent training because religious and spiritual issues may be areas of concern in patients' lives, which may bring them to treatment, but the client's religion and spirituality may also be sources of strength and support that may help them to access and utilize ongoing psychotherapy treatment (Barnett, 2016). In the past, mental health professionals lacked respect for religion and spirituality in the psychotherapy process. However, the residents in this study suggested improvement in the cultural competency residency training should include collaboration with religious leaders. The residents suggested the involvement of community leaders would be helpful in patient engagement. Resident 2 suggested, "Get the religious leaders, like the minister, the Imam, to come and speak to us (residents) to give us their perspective on how to talk to patients from a different culture who are more conservative." The residents suggested that it is important to engage essential members of the community to facilitate the transmission of information that is culturally relevant to patients. Categorical approaches to cultural competency training can be impactful when local cultural experts are solicited to assist in practice about the culture of the local-level population (Jongen et al., 2018).

The suggested implementation of professional spiritual relationships will not only help provide clients with the most appropriate and helpful care possible but also serve as useful referral resources in meeting patient's needs through religious or spiritual

discussion. Developing a group of committed community religious leaders who will participate in the cultural competency training can provide spiritual and religious insight, yielding more prominent access to spiritually diverse patients and an understanding of how to develop culturally responsive mental healthcare. Thus, cultural competency training practices should not only include religious involvement but also include therapy and materials in the client's language. An understanding and appreciation for cultural perspectives can enhance client engagement and plans for retention and treatment of culturally diverse patient populations.

Sensitivity to Language

Immigration to the United States results in a higher prevalence of depression among immigrants and refugees compared to the general population because they are less likely to obtain mental health services (Njeru et al., 2016). This population has increased by 80% in the past two decades and has limited access to culturally responsive mental healthcare, establishing a need for tailored interventions in cultural competence training and language navigation (Njeru et al., 2016). Language barriers are of great concern regarding health disparities in treatment adherence among racial and ethnic groups living in the United States. For example, for Latinos, language continues to be a significant barrier to patient treatment adherence and leads to poor health outcomes in addition to the cultural sensitivity of providers (Nielsen, Wall, & Tucker, 2016).

Further, according to the United States Census Bureau, 21% of Americans speak a language other than English at home, but patients with LEP only receive an interpreter with a physician 14-17% of the time (Mechanic, Dubosh, Rosen, & Landry, 2017). The

residents reported concerns about the availability of live interpreters as burdensome. Resident 5 shared that the availability of live interpreters is limited, and they are "restricted to only specific languages… such as Spanish …and are available during daytime hours only" and "not available on a 24-hour basis comparable to the hours of operation of the hospital center." Therefore, it is important to advance services and training with patients with LEP in cultural competency training. Integrating elements that have been shown to improve healthcare access, such as community engagement, and the incorporation of training among language-congruent community health workers can lead to culturally competent care and better patient engagement (Njeru et al., 2016). However, residency programs have been shown to only include 40% of elements that address patients with LEP (Mechanic et al., 2017).

With health disparities posing the greatest threat to culturally diverse populations and few residency programs incorporating LEP, this study reiterates the need to include LEP training in the cultural competency training for the residents at the study site. To implement LEP training would build on the necessary and desired objectives for the culturally diverse patient population and the culturally diverse residency program, respectively. Implementation of this initiative will serve as cutting edge cultural competency training for psychiatric residents.

Language immersion training. A learning strategy in addressing the medical needs of individuals with LEP recommends bridging the linguistic gap between the patient and the provider. Advances in medical education practices suggest the implementation of a Spanish-language immersion curriculum for resident physicians.

This curriculum enhancement includes language and cultural instruction incorporated into the current training didactics.

The Hispanic population is the fastest-growing population in the United States (Mechanic, et al., 2017; Nielsen et al., 2016; Njeru et al., 2016). According to Grall, Panchal, Chuffe, and Stoneking (2016), the rapid growth of this population is the result of the widening language and cultural gap. In addressing the needs of this growing Hispanic population, the residents' training will only benefit from the implementation of a language immersion-training component for the current training of the residents.

Ivers and Villalba's (2015) research examined the effect of bilingualism on counseling students' multicultural counseling competence among 178 master's degree level multicultural counseling students. The study suggested culture and language are interconnected, implying learning a second language would facilitate multicultural counseling development and a benefit in the delivery of quality counseling services for non-English speaking clients. The findings of this study support bilingual counselor training programs and suggest adding culture matters and language as part of their program guidance (Ivers & Villalba, 2015). Bilingualism positively influences multicultural awareness and knowledge. Knowing this information may be both responsible and reasonable for providing additional language training opportunities to students, such as second-language training courses (Ivers & Villalba, 2015). The implications of this study suggest the addition of second-language training could not only enhance access to counseling for LEP patients but enhance counselors' multicultural

counseling knowledge and awareness, thus, establish cultural and linguistic skills necessary to serve the increasingly LEP patient population effectively.

Empirical data indicate 13.1% of the United States population speaks Spanish, and 41.6% of these Spanish speakers report speaking English less than well (Aitken, 2019). Aitken (2019) stated that LEP patients often defer needed medical attention because of language barriers and suggested the use of interpreters that received training and certification as a means to improve healthcare for patients with LEP. Aitkin (2019) indicated there is a shortage of trained interpreters nationwide, which disproportionately impacts free clinics where a majority of LEP patients receive care.

According to Aitkin (2019), the introduction and implementation of the Loyola University Chicago Stritch School of Medicine nine-hour course in interpreting techniques and language skills to bilingual first-year and second-year medical students fills the gap in the absence of certified medical interpreters. Aitkin (2019) reported that trained medical students not only increased in self-perceived interpreter efficacy but also patient and physician satisfaction. The participation of medical students in interpreter certification training could be provided as a benefit by increasing in-person interpreter availability, providing second language acquisition skills, and producing well-trained, culturally competent Spanish-speaking clinicians who can meet the linguistic needs of LEP patients. The implementation of this type of program enhancement could be applied with minimal effort and offer a significant benefit to the current residency training program in the treatment of LEP patients.

Additional solutions in addressing residency training in language immersion were studied in the research conducted by Cardinal, Maldonado, and Fried (2016). This national confidential survey with residency directors sought to address issues related to patients with LEP. Cardinal et al. (2016) recommended standardizing mechanisms that could assess residents' competency to communicate in languages other than English for medical care. The researchers determined through the implementation of this effort, attention should be placed on developing a learning environment that promotes skilled and patient-centered practices among residents.

Program Evaluation

Currently, there are no evaluation tools in the residency-training program. The implementation of a valid and effective assessment tool will not only enhance the evaluation of the current training program, including its impact but also provide feedback to the residency training director. This recommendation is supported in recent studies and suggests the implementation of evaluation can improve the planning of cultural competency training. In a systematic literature review of cultural competency interventions in health care in Canada, the United States, Australia, and New Zealand, Jongen et al. (2018) reviewed 64 studies on cultural competency interventions. A thematic analysis was used to identify critical interventions and strategies which could improve cultural competency training. The review highlighted support for systematic program evaluation of cultural competency services. The endorsement and implementation of program evaluations improve outcomes in satisfaction levels, service

utilization, and essential indicators of cultural competency training intervention services (Jongen et al. 2018).

Jongen et al. (2018) conducted a literature review of cultural competency programs focusing specifically on health care workforce interventions. This research was gleaned from their earlier systematic literature review of the 64 studies and concentrated on the 16 studies that specifically focused on the health workforce. Their discussion of the literature posited that evaluating workforce cultural competence training could impact patient health care and health outcomes, but only minimally. However, the evaluation of behavioral outcomes of the providers in seeking results related to knowledge and learned skills was found to be advantageous to cultural competence training programs (Jorgen et al., 2018). This study substantiated the need for program evaluation to discover if the implemented program enhancements imparted skills to the residents in the cultural competency residency training program.

Interestingly, Jongen et al.'s (2018) review of the literature warned against using self- reported evaluation measures. Although a popular choice of assessment used in 69% of the included studies, self-reported measures are "highly subjective" and not predictive of resulting behavior in clinical encounters due to human and social biases. The study suggested improving the objectivity of evidence-based evaluation of cultural competency training by combining patient-assessed-practitioner cultural competence with health and healthcare outcomes. The study concluded that there is a need for consistent evaluation approaches to contribute to evidence-based interventions and applications of knowledge, attitudes, and skills that impact practitioner behaviors in cultural competency training.

In a study conducted by Cardinal et al. (2016) using a confidential survey with residency program directors, the researchers sought to understand the efforts of internal medicine to meet the accreditation requirements for cultural competency medical education. The results indicated 45% (177) of the 391 program directors responded; approximately 25% shared that they evaluated residents on their "aptitude to demonstrate culturally competent care (Cardinal et al., 2016). The study also concluded that despite a robust majority of the program directors, 70% surveyed established a commitment to reducing healthcare disparities, and only 14% of them reported having the means to evaluate language competency in languages other than English for residents communicating with LEP patients. This data supported the need for valid and effective assessment tools in these areas.

Cardinal et al. (2016) recommended a review of Kern's six steps for curricular development as a model of what constitutes a culturally competent physician-training program with practical evaluation and feedback. According to the study conducted by Noriea et al. (2017), utilizing Kern's six steps with 16 medical residents, the evaluation component of Kern's six steps positively addressed learner outcomes that comprehensively reflected the curriculum. The application of the learner outcomes addressed self-reported survey questions such as: (a)"how prepared will residents feel to care for patients of other cultures?"; (b) "how skillful will they be in providing cross-cultural care?"; and (c) "will resident attitudes change?" (Noriea et al., 2017, p.798). The residents' preparedness in caring for unique patient populations and providing various aspects of cross-cultural care was measured by pre and post online surveys. The outcome

of Noriea et al.'s (2017) study indicated high practicality of the curriculum implementation and successful program and learner outcomes.

Educating residents while providing cross-cultural care is essential and required in medical curricula. Unfortunately, the teaching methodologies vary, and methods of evaluation are lacking. Green et al. (2017) sought to understand medical students' perspectives on their cultural competency across a four year curriculum using a validated survey instrument. The study was conducted through an annual Internet-based survey for four consecutive years at Harvard Medical School with medical students. The tool was validated with residents and modified for the medical students to assess and understand their preparedness, skillfulness, and perspectives on the curriculum and learning environment.

From the research of Green et al. (2017), it is evident that there is significant variability in the content and teaching methods of some schools which concentrate more on the social plan and less on pragmatic abilities. From the study, we discover the variation in training also minimizes partiality, typecasting, and inequalities. With this type of difference in medical education, a standard evaluation of the training program is necessary. Applying standard access tools such as the Association of American Medical Colleges for Assessing Cultural Competence Training allows medical schools to review how cultural competency has been implemented. However, it falls short in assessing students' attitudes toward cross-cultural care. The recommendation for an evaluation tool is not to determine the implementation of a cultural competency training, but to evaluate

and measure the skills and preparedness of the residents to deliver culturally responsive mental healthcare.

Green et al. (2017) developed the Cross-Cultural Care Survey (CCCS) to assess self- perceived skills and preparedness to deliver cross-cultural care among the residents and to evaluate the learning environment at their institution. The responses of 1369 students concluded skillfulness, knowledge, and preparedness were valued measurements in medical training. In addition, the study illustrated the value of program evaluation to assess the effectiveness of the training curriculum. The CCCS was found to be a valuable longitudinal assessment tool that could be applied to determine medical students' perceived preparedness and skillfulness to care for culturally diverse patient populations. The CCCS is an excellent curricular assessment tool to help guide curricular enhancement in cultural competency and track individual residents' perceived cultural competency.

The recommendation of future program evaluation will not only benefit the residency director in implementing evidence-based training practices but also measure the residents' needs and ability to deliver culturally competent mental healthcare. The implementation of Kern's six steps curricular development model components is noted to be generalizable, beneficial, and applicable for the evaluation of residency training programs. Therefore, it is recommended that the residency training director conduct a blend of the suggested evidence-based assessments including: (a) Kern's six steps to measure curricular development; (b) psychodynamic training in cultural psychiatry; (c) the language immersion training to assist in developing the cultural competency training

and increasing the potential for additionally trained interpreters for the LEP patients; and (d) the CCCS to assess self-perceived skills and preparedness to deliver cross-cultural care among the residents and to create and implement a useful cultural competency training evaluation.

The literature review produced the following key findings: (a) the introduction of culture into cultural competency training of mental health residents who are working with culturally diverse patient groups improves the delivery of mental health care to ethnically diverse patient populations; (b) the introduction of community spiritual and religious leaders to the cultural competency training provides value in addressing psychotherapy with a culturally diverse patient population; (c) the increase in globalization and migration has necessitated the importance for mental health providers to become linguistically competent to meet the delivery of culturally responsive mental health care; and (d) accountability and assessment of cultural competency training needs to be ongoing, formal, and transparent, involving all residents and training administrators. These findings support the development and distribution of a structured document that explores the enhancements but also identifies and explains how to create and maintain them. A white paper is an efficient and time-effective way to communicate this information due to the time constraints of medical providers at an active medical center.

Project Description

The project deliverable for this study is a white paper with planned distribution at the annual resident training development meeting. A PowerPoint presentation and hard copies will be distributed for review at the meeting for review.

Needed Resources

The formal support in the adaption of the program enhancements will be from the resident director in the implementation and coordination of new enhancements included in this paper. Sanction support would be needed from the director of psychiatry and director of resident training to ensure inclusion in the core curriculum necessary for ACGME credentialing. In terms of the training facilitators, needed support would involve motivation toward the implementation of the curriculum additions and problem-solving during the implementation of the projected program enhancements will be required for success.

The director of information technology (IT)will be needed for the development and implementation of the online training and evaluation. The director of language services will be needed to assist with the implementation and evaluation of language competencies of the interpreter training services for the residents. Lastly, the residents' buy-in would be crucial in each of these areas and their continual evaluation of the program enhancements to ensure authenticity and permanent implementation into the cultural competency training of psychiatric residents.

Existing Supports

The existing psychiatric resident cultural competency training will serve as the foundation for the implementation of the program enhancements. The current training program will serve as the groundwork for the implementation of the recommended enhancements of the psychiatric residents for improvement of their current cultural

competency program. The support of the residency training director will be an essential resource for the implementation and sustainability of the project.

Potential Barriers and Solutions to Barriers

Potential barriers to the recommended enhancements can come from the residents if the expansion in the curriculum results in additional training time. Resident 2 requested that cultural competency training begin sooner than later, suggesting training should "begin in orientation rather than six months into it." Residents reported computer-based learning as a preference. The curriculum expansion can be a barrier to residents if the curriculum expansion is not taught in the preferred computer-based pedagogy. The solutions to the potential obstacles would require timing the implementation of the curriculum during orientation in year one of the psychiatric residency training program. A second solution would include the expansion session and the evaluation in a computer-based format for acceptance by the residents. Lastly, I will ratify all recommendations with peer-reviewed references to ensure evidence-based practices are correctly applied.

Implementation

The full implementation of the recommendations outlined in the project white paper will occur in the new residency training year in July 2021 and will require collaboration from all stakeholders. The residency director will present the initial findings from the winter pilot of the program enhancements and assist in the implementation plan for the 2020-2021 residency training. The implementation of the program enhancements for the white paper will be conducted during the pilot. During this pilot, the residency director of psychiatry, director of residency training, director of psychiatry, chief

residents, and training facilitators will share the progress as the implementation continues with the program enhancements of the psychodynamic cultural psychiatry curriculum, Kern's six steps instruction, the language immersion training, and lastly the CCPS for evaluation.

The timing of the training is essential to residents, as expressed by Resident 2, who "values cultural competency training" and supports the initiation of continued education "at the start of residency training rather than later." The residents' preference for computer-based learning, as opposed to the traditional lecture format of training, is apparent from the study. The recommended program enhancements will be developed into computer-based training scenarios for useful multisensory learning of therapeutic techniques in delivering culturally sensitive mental health care. The projected enhancement sessions will improve the introduction/timing of the cultural competency training and introduce fundamental concepts that assist with enhancing the importance of cultural competency training.

Upon approval of this doctoral study, findings, and implications, the initial draft of the white paper will be shared at the residency training planning committee meeting. This meeting includes the residency training director of medical training for the study site, residency training director of psychiatry, the director of the Department of Psychiatry, and the chief residents of psychiatry, director of information technology, and the director of language services. The findings will be shared along with a proposed implementation schedule, at which time the residency training director will also offer to meet with the facilitators to help draft training initiatives for the implementation of the

recommended enhancements. The application of the theory-based program enhancements project will impact the cultural competency training of the PYG1 residents. The gathered data from the CCPS evaluation tool will provide ongoing evidence on the impact of the psychodynamic cultural psychiatry curriculum, Kern's six steps instruction, and language immersion training. The collected data will assist the psychiatric residency training director and the residency training committee members with evaluating and refining the program enhancements as needed during the implementation, a process known as formative evaluation. The findings and the proposed implemented schedule will be shared along with opportunities for me to meet in small groups with other hospital leadership to help draft any additional plans. The psychiatric residency training will serve as the initial site for implementation of the program enhancements. The current first year psychiatric residents will be used as participants for the pilot implementation.

Dates will be determined to conduct the program enhancements in the current cultural competency training within the psychiatry department. Data collected from the initial implementation of the psychodynamic cultural psychiatry curriculum, Kern's six steps instruction, and the language immersion training will assist in determining problems in training and evaluating solutions utilizing the new evaluation assessment tools. The residency training director will share findings from the implementation of the program enhancements with the entire residency training committee, other psychiatric residency-training directors, program facilitators, and chief residents enrolled in enrolled within the study site's residency training program. From the input of the group, the residency

training director will develop an implementation plan based on findings and experiences of the residents, facilitators, and program directors of IT and language services.

2020-2021 Full Implementation

Full implementation of the project will occur in the 2020-2021 residency training year. A summary of the application and evaluation is shown in Table 2. This format will allow the implementation of participants to have input. It will enable the residency training director to take the lead in presenting information to the resident training committee at the study site. The residency director at the study site will present the initial findings and experiences from the winter pilot and share the implementation plan for the 2020- 2021 residency training year with the residency training committee and other interested urban community Hospital psychiatric residency training directors.

Before the full implementation, program facilitators will participate in professional development training to learn about the new program enhancements. The resident director will set the schedule for the facilitators and the director of services to participate in the planning and review of the implementation of the program enhancements. The data gathered will continue to provide evidence regarding the impact of the program enhancements that will assist in refining and restructuring training elements as needed. The training goals of these program enhancements will enable the psychiatric residency director to recognize the psychiatric residents' understanding of the importance of culture in their cultural competency training. In addition, it will build skills in language sensitivity for limited English patients. Lastly, it will highlight ongoing resident perceptions of their training interventions through program evaluation.

Beginning cultural competency training early in training will assist with skill-building and the application of learned knowledge by the new first-year psychiatric residents.

Table 2

Summary of Implementation and Evaluation

Action	Type	Audience or Participants	
January 2020 Present study and white paper to residency training committee	Implementation	director of residency training for the study site director of psychiatry residency training	‣ director of psychiatry ‣ chief psychiatry residents ‣ IT director ‣ director of language services
February 2020 Introduce psychodynamic cultural psychiatry, language Immersion training, religious intervention with community leaders, and evaluation assessment tools: Kerns six steps & CCCS	Formative Summative	director of residency training for the study site director of psychiatry residency training director of psychiatry	‣ chief psychiatry residents ‣ director of language services ‣ director of IT services
March 2020 Development of timelines for identified curriculum enhancements	Formative Summative	director of residency training for the urban community hospital director of psychiatry residency training director of psychiatry	‣ chief psychiatry residents ‣ director of language services ‣ director of IT services
April 2020 Introduce facilitators to curriculum enhancements and new timelines	Implementation	director of psychiatry residency training	‣ chief psychiatry residents ‣ training facilitators
May 2020 Conduct lessons in program enhancements in psychodynamic cultural psychiatry, language immersion training, religious intervention, implement new evaluation tools: CCCS & Kerns six steps	Formative Summative	director of psychiatry residency training chief psychiatry residents	‣ training facilitators ‣ current first-year residents
June 2020 Review outcomes of CCCS evaluation tools on the Kern's six steps instruction, psychodynamic cultural psychiatry instruction, religious leaders' intervention, and interpreter training and language Immersion	Summative	director of residency training for the study site director of psychiatry residency training director of psychiatry	‣ chief psychiatry residents ‣ director of language services ‣ director of IT services
July 2020 Implement new program enhancements		new first-year psychiatric residents	

Role Responsibilities

Nousiainen, Caverzagie, Ferguson, and Frank (2017) suggested three aspects for implementing competency-based medical training education that included: (a) organize the structural changes needed to implement the new program enhancements and its evaluation; (b) modify the current processes of teaching and evaluation; and (c) maintain clear communication and support from all stakeholders involved in the change process. As a program evaluator, my role is to introduce to the stakeholders the curricula enhancements, the evidence supporting the upgrades, and an evaluation assessment tool which could evaluate the changes. Additionally, I will introduce the specific timelines to guide the implementation of the changes and to provide instruction to assist in embedding the targeted enhancements into the psychiatric residents' training program with the least interruption, but the most significant impact for program improvement.

The residency training director will be responsible for the administrative duties, including scheduling meetings to review and discuss the recommended enhancements and provide and train program facilitators on the improvements. Additionally, the training director will create the schedule for the implementation of the recommended improvements. The administrative duties include building collaborations between the IT department to develop electronic formats for the recommended training enhancements and program evaluation. In addition, the information technology department will develop and foster cooperation with the department of language services in order to introduce and implement the interpreter training initiative. The director of psychiatry will be responsible for obtaining approval for the adaptation and implementation of the

recommended program enhancements from the governing regulatory boards of the study site, and the residency training credentialing entities of ACGME.

Project Evaluation Plan

This study used a comprehensive evaluation approach to include both summative and formative features. According to Lodico, Spaulding, and Voegtle (2010), program evaluators often use summative and formative evaluation data to report back to the stakeholders. Formative evaluation helps to prepare for the summative assessment by improving program processes and providing feedback about strengths and weaknesses that affect goal achievement**.** The formative data will be collected and assessed to make changes or improvements. This evaluation will help to document needed modifications in the cultural competency training. Examining the various proposed enhancements at the implementation stage ensures that the quality of the program implementation is maintained. The evaluation data will be collected within the determinative and planning stages of the program enhancements before program implementation.

The summative evaluation will take place at the end of the 2021-2022 residency training year and involve the first-year residents. The outcomes-based summative evaluation will determine whether the benchmarks, goals, and objectives of the program were met. The review of the program enhancements will not only provide the evaluation of the upgrades but also highlight to the stakeholders, residency director, and director of psychiatry that the implemented improvements are a valuable benefit to the overall psychiatric residency-training program.

Kern's Six-Step Instructional Curriculum

A formative evaluation of the implementation of Kern's six-step instructional curricula will take place in the pilot stage to determine if the program is being implemented as according to the design. The formative evaluation will query if the curricula are being implemented on schedule and if there is sufficient time to perform all aspects of the curricula within the allocated timeframe. The summative evaluation of this program enhancement will measure the residents' preparedness in caring for unique patient populations and skills needed to provide relevant aspects of cross-cultural care through patient satisfaction surveys and patient outcomes. A posttest design with open questions (See Appendix D) will be used to determine the effectiveness of the training on the residents' knowledge of cross-cultural communication and diversity. Both evaluations will be beneficial to the residency director in the implementation of the program enhancements.

Implementation of Religious Leaders

The curricula and religious leader presentation will be used to determine the residents' confidence in interacting with different races/ethnicities by identifying and defining the impact of these initiatives in their cultural competency training. The formative evaluation will aid in determining, evaluating, and refining practices and presentation structures as needed during the implementation (See Appendix E). The summative evaluation will be conducted to determine if these program enhancements helped to improve the cross-cultural relationship between residents and their patients via a focus group interview with the participating residents. Both evaluations will be

beneficial to the residency director in the implementation of the program enhancements and the improvement of the residency training in cultural competency.

The Interpreter Training

The interpreter training will be implemented to improve the residents' ability to integrate language and their interaction with patients with LEP. The formative evaluation of this program enhancement will include observation and documentation of behaviors of resident and patient interactions to determine the use of the learned skills. The summative evaluation will consist of a bilingual fluency assessment for clinicians, to assess the clinician's oral proficiency and fluency in medical terminology (Solutions, L. L, n.d.). Eighty percent of the participating residents will be able to provide mental health care in a second language. The benefactors of this interpreter training evaluation include the residents who will be able to determine their abilities to provide their diverse patient population with language-sensitive mental healthcare without the need for translators or translation devices. Secondly, the study site will benefit from an increased number of certified clinicians who can provide its diverse patient population with culturally sensitive mental healthcare in their preferred language.

Program Evaluation

The summative evaluation will be conducted at the end of the pilot and include the Program Enhancement Cultural Competency Program Survey (CCPS) evaluation tool (See Appendix F) to determine the effectiveness of the program enhancements. The CCPS will assess the residents' preparedness to treat their culturally diverse patient population. The evaluative impact of the new program enhancements will determine if

this change in the psychiatric residency training program improved the residents' ability to deliver culturally responsive mental healthcare in 90% of the residents. The evaluation results will be beneficial to the residency director in the implementation of the program enhancements in cultural competency training to determine residents' attitudes, skills, and knowledge.

Project Implications

Consistent with the findings in the literature, I learned that minorities are disproportionately affected by most diseases and illness and have experienced a legacy of unequal healthcare practices in the United States (Aggarwal et al., 2016a; Cushman et al., 2015; Jongen et al., 2018; Njeru et al., 2016). Factors contributing to unequal healthcare impact the patients, clinicians, and the healthcare system and need to be evaluated. This research study on cultural competency training has the potential to elicit social change in the delivery of culturally responsive mental health care.

Understanding the perceptions of resident psychiatrists in cultural competency training provides a basis for improving training content and practices to establish means to mitigate disparities in the delivery of mental health care. The implications for psychiatric residents learning how to deliver high quality, culturally responsive mental health care point to a greater shared understanding and delivery of cross-cultural mental health care. Data from this study support the above assertions and provide clear direction for residency training directors to create an innovative cultural competency residency training program. The project implication applies theory-based training initiatives based on the current needs of psychiatric residents treating a culturally diverse patient

population. The implications support what residents want and need to manage their patient population, assist the residency training directors, and support the director of psychiatry. The project implications set a clear schedule and expectations, which is also paramount to the implementation and coordination with auxiliary departments (information technology and language services) to support it, and ensure consistency in implementing the plan effectively.

Through implementation, the residency training director must continue to collect data and redirect as needed, so that new psychiatric residents entering the training program will obtain the necessary training to treat their culturally diverse patient populations. The positive social change implications incorporate useful knowledge for psychiatric residents, cultural competency trainers, and other researchers seeking knowledge and understanding about psychiatric training residents' needs and desires from cultural competency training that effectively meets the needs of a culturally diverse patient population.

Conclusion

In this section, the presentation of a white paper is used to share program enhancements. This white paper will provide the stakeholders at the study site's psychiatric residency training program with the information needed to implement the program enhancement in the psychiatric residents' cultural competency training. The white paper contains a literature review of program enhancements in cultural psychiatry, religious involvement, language sensitivity, and the new program evaluation assessing the impact of the cultural competency training of psychiatric residents treating patients

from diverse cultural backgrounds. In addition, this section a description of a white paper was provided and how it could be used to disseminate the findings and recommendations of this study. Lastly, Section 4 includes self-reflection, self-analysis, and suggestions for future studies.

Section 4: Reflections and Conclusions

Project Strengths and Limitations

Due to the rapidly changing demographic profile of the United States, the nature of healthcare environments consists of patients from culturally disparate communities seeking medical attention. Therefore, healthcare professionals and institutions are increasingly being asked to bridge the cultural differences between them and their patients. Cultural competence is a wide-ranging concept with varying theoretical underpinnings and conflictual opinions on how to best introduce or implement training (Loue, Wilson-Delfosse, & Limbach, 2015). Thus, my study was designed to address the best means to deliver cultural competence training and focused on: (a) cultural awareness in developing cultural competency training; (b) language sensitivity in the medical treatment of LEP patients; (c) the extent to which psychiatric residents believe they can deliver culturally responsive mental health care to their diverse population based on their cultural competency training; and (d) program evaluation in meeting the changing societal framework of cultural competency training. This section presents a reflection on the project study, including strengths and weaknesses and my learning and growth.

Project Strengths

This study was conducted to highlight program enhancements for the residency training leadership program and to assist with the implementation of new strategies to improve the existing cultural competency psychiatric residency training program. Strengths of this project include program enhancements related to different training

content to address cultural competency education regarding best practices with communicating with patient populations with cultural differences.

Recommendations. A strength in this project is exemplified in the individual recommendations of the project study. Based on the findings, four proposals will be presented to the residency training leadership committee. The recommendations include program enhancements to directly address improvement in the cultural competency training for future psychiatric residents. The proposals involve the integration of education to meet the needs of a diverse patient population, clinical redesign efforts as a renewed focus on patient experience, communication, and evolving clinical training practices that are aligned to support innovative methods and support professional growth in cultural competency health care education.

Intervention type. A strength of the project is the delivery mode of the new training content. As suggested by the residents, the training format will use mixed teaching methods, which will include lectures, interactive lessons, and a varied duration in the delivery of the training materials for easy integration into the current cultural competency training sessions.

Project Limitations

One limitation of this project is related to the cost of the implementation of the program's enhancements. An economic analysis of the program enhancements is needed to understand resources and potential cost-effectiveness of the interventional approaches designed to improve cultural competency training in the residency training program. The

second limitation of the project is related to the limited perceptions of psychiatric residents enrolled in one residency-training program.

Recommendations for Alternative Approaches

Based on the limitations of this study, there are recommendations for alternative approaches to address possible ways to improve the project: (a) expand the sample size of the study; (b) recruit residents from all NYC public hospitals with a psychiatric residency training program; and (c) include psychiatric residents from other psychiatric training programs. It is also essential to include residency-training directors to examine the thoughts and feelings of these administrators when developing comprehensive training in cultural competency for psychiatric residents. It is also necessary to include the perspectives of patients receiving mental healthcare to determine what their needs are in receiving culturally responsive mental healthcare. These alternative approaches may provide essential insights into the delivery of culturally sensitive mental healthcare.

Scholarship, Project Development, and Leadership and Change

Self-Analysis

Self-analysis requires reflection on personal beliefs and identifying how these beliefs impact a study. In the development of this study, I thought I could project findings and foresee the psychiatric residents' needs based on the responses of the CHNA previously conducted at the study site. However, through this process, I have been able to look at their perceptions and belief systems related to cultural competency and build a more robust outlook on residency training initiatives associated with a culturally diverse

patient population. From this study, I learned advocacy, learning styles, preferences, and leadership can change.

Scholarship

An advocate is someone who petitions the cause of another. Health advocacy causes in guaranteeing access to mind, exploring the framework, activating assets, tending to wellbeing disparities, affecting wellbeing strategy, and making framework change (Hubinette, Dobson, Scott, & Sherbino, 2017). Advocacy is intended to safeguard good patient care. The intended paradigm at the start of this study was to develop a "how-to" manual for foreign-born or trained culturally diverse psychiatric providers in the treatment of a culturally diverse patient population. As the administrator of an adult psychiatric clinic, I was confronted by patients their culturally diverse clinicians implement changes in their delivery of care and interactions because they claimed that they did not understand them. When I began my inquiry, I was advocating for these patients; however, the advocacy changed to assist the residents with obtaining what they needed to treat the patient population.

In advocacy/participatory research, the inquiry should be tied to politics to strive for action that can change the lives of the participants, institutions, or researchers, addressing disparity, abuse, mastery, concealment, and distance (Creswell, 2009). Learning the perspectives of the psychiatric residents concerning their cultural competency training fostered collaboration between the residents and me, which was used as the voice for social change and equality in the delivery of culturally responsive mental healthcare. This collaboration can be used to advance residents' agenda for

necessary changes in their cultural competency training to improve patient care at the study site. This study became their united voice for reform and change at the institution and a change in practice. This study has strengthened my appreciation for the advocacy/participatory approach in research and heightened awareness in advocating for change.

Practitioner

Learning styles and preferences are things I had very little knowledge of before this study. Developing a learning environment for health professionals is very complicated. Understanding learning styles helped me to become aware of the best approaches for training and to select the most effective and efficient learning opportunities that align with the residents' preferences. Bradshaw and Hultquist (2016) suggested the key to active learning occurs when educators are knowledgeable. As the practitioner, acknowledging learning preferences aided me in understanding what would help to engage the residents in learning and applying learned skills in cultural competency training.

Project Development

The delivery of quality healthcare has been a passion of mine since my start in healthcare over 36 years ago. My enthusiasm for conveying the most patient-centered perspective is my intention to improve care, patient satisfaction, health outcomes, and an increase in the utilization of healthcare institutions by culturally diverse patient populations. As the administrator of several psychiatric clinical services, it has been my responsibility to work with the interdisciplinary clinical team in meeting the mental

health needs of culturally diverse patient populations. I understood that training changes were needed, and I recognized that a collaborative effort would be crucial in facilitating the required exchanges between the patients and the psychiatric residents.

Reeves (2016) suggested improving the delivery of safe and effective care through the implementation of interprofessional education (IPE). Reeves defined IPE as two or additional vocations acquire by way of, from and about one another to improve joint effort and the nature of care that is high quality (Reeves, 2016). Applying the concepts of the IPE would be useful to initiate a successful exchange in the development of the change in the cultural competency training of the psychiatric residents. As a clinical administrator, I could not be independently responsible for making culturally accountable changes. However, I learned throughout my research that the perspectives of the residents, resident director, and patients could shape the possible next steps needed to develop the training necessary to bridge the gap in the delivery of culturally competent mental healthcare.

Reflection on the Importance of the Work

In my tenure as a hospital administrator, I always wanted to work more closely with the clinical team to bridge the gap between the culturally diverse patient population and the culturally diverse psychiatric health care providers at the study site. This study allowed me the opportunity to do just that. The examination of the residents' training in cultural competency highlighted the standard level of cultural competence and what would enable them to work in cross cultural situations effectively. The study assisted in

tailoring training to meet psychiatric residents' perspectives in delivering cross-cultural care.

The work illustrated residents' recognition of the importance of cultural issues in healthcare and shared the paramount importance of being prepared to address culturally related topics. However, a lack of specific or explicit cultural training may underestimate the needs of patient populations and render residents unprepared to meet the healthcare needs of their culturally diverse patient population. Therefore, utilizing the perspectives of the residents in developing the specific training enhancements needed to meet their training needs was essential in the development of preparedness in the delivery of cross-cultural mental health care.

Implications, Applications, and Directions for Future Research

Initiating social change in the delivery of culturally responsive mental health care will require healthcare providers to deal with people in a thoughtful and effective manner to mitigate health disparities. The integration of the program enhancements into the psychiatric residency cultural competency training will assist in a positive social change by acknowledging and shaping the multicultural and culture-specific knowledge of the psychiatric residents in the delivery of culturally responsive mental health services. The program enhancements will assist the residents in becoming more capable in their capacity to understand and interact with patients from different cultures. Through the implementation of the program enhancements, the residents will be able to provide services that are responsive to the health beliefs and linguistic needs of their diverse

patient population by improving cultural competence and ethnic diversity in mental healthcare.

The implementation of the recommended program enhancements will influence positive social change by providing learning opportunities for psychiatric residents when examining personal biases and supporting the residents to negotiate the successful deliver of culturally diverse mental healthcare. Positive social change will also be acknowledged in the development of cultural empathy among providers and a critical analysis of cultural competency training to promote continued dialogue and an understanding of the treatment of culturally diverse patient populations.

Data from this project study show psychiatric residents want and value cultural competency training; however, the residents would like enhancements to improve their instruction to meet the needs of their culturally diverse patient populations. According to Green et al. (2017), the variability of cross-cultural education lacks standardization and hence hinders the practical skills of residents. Despite the implementation of cross-cultural knowledge, there is variability in content and teaching approaches inhibiting the outcomes of implemented cultural competency training curricula. Without evaluation of cultural competency training curricula and standardization of the cultural competency training, it will be difficult to understand the effect on the residents' learning.

My findings imply that residency training directors can better understand the wants and needs of the residents while establishing best practices for delivering culturally responsive mental healthcare to a culturally diverse patient population. In response to themes and patterns that resulted from the project study, I conducted an in-depth

literature review of cultural competency training, language immersion, and evaluative assessments. These three determinants contributed to a review of the cultural competency training to initiate the implementation of what is needed by the residents in the medical practice. The application of the suggested strategies of the residents and continued evaluation of these strategies are what could be considered best practices for delivering culturally responsive mental healthcare.

Future research could be implemented using a qualitative study conducted with patients of the first year residents who participated in the program enhancements. Data from this project would give insight into how patients perceive the delivery of the residents' enhanced training and determining the impact of the newly implemented training enhancements. The data could further guide residency directors in refining, enhancing, and evaluating their residency training programs in the delivery of culturally responsive mental healthcare.

Conclusion

The focus of this study was to learn the psychiatric residents' perceptions of their cultural competency training in the delivery of culturally responsive mental healthcare. The research was based on the residents' perceptions of their current training in cultural competency. Section 2 provided a highlight of the data, the analysis of the data, and residents' suggestions for additional training to meet their needs in the delivery of culturally responsive mental healthcare. Specific to the suggested program enhancements include additional training in cultural psychiatry, language immersion in the treatment of limited English patients, and involvement from community religious leaders. For the

benefit of the residency training director, the implementation of program evaluation is introduced to improve cultural competency training and assessment of both intervention strategies and intervention outcomes.

Today, health policymakers, managed care administrators, those in academia, providers, and consumers support the movement toward cultural competence in health care. The delivery of culturally responsive healthcare is recognized as a strategy to eliminate racial/ethnic disparities in health and healthcare and to support social change. Implementing structural changes in cultural competency medical curricula could assist in systemic cultural changes in healthcare delivery and reductions in healthcare inequalities.

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Appendix A: White Paper

November 10, 2019

The disparities in health care and access to healthcare have been a threat to the culturally diverse patient population of [redacted] Through the psychiatric residency training, you have created an arena for preparedness in cultural competency training for psychiatric residents. A current study of the psychiatric residents' perceptions of their training in cultural competency suggested their support in the ongoing instruction in cultural competency in the delivery of culturally responsive mental healthcare.

The results also indicated a need for program enhancements to build a better understanding of culture, and more resources to communicate effectively with the limited English patient population outside the solicitation of interpreters. Essential in the program enhancements would be the implementation of ongoing program evaluations to ensure the effectiveness of the curricula, and to determine the ongoing training needs of the residents. The evaluative structure will aid in the implementation of the most current, prevalent, and relevant training initiatives in the cultural competency training of residents.

The changing population of [redacted] and the care of the different races, ethnicities, gender identity and sexual orientation, and limited English proficiency have been a priority for physicians and in the training of future physicians. Adjusting, and minimally altering, the current residency training in cultural competency will improve the psychiatric residency training program in meeting the health care needs of the culturally diverse patient population of [redacted].

The projected program enhancements contained in this paper are sure to assist in developing relevant cultural competency training for both you and the psychiatric residents. It would be my pleasure to address questions or clarification on anything contained in this paper; please feel free to contact me [redacted]

Best Regards,
Carol Matthews

Cultural Competency Training for Psychiatric Residents:

A White Paper of Recommendations for Program Enhancements

By Carol Matthews, MS, MSW

In meeting the unique needs of a diverse patient population, healthcare organizations endorse having ethnically or socially similar practitioners. In the absence of a culturally similar healthcare workforce, cultural competency training becomes a necessity in the delivery of culturally responsive healthcare. Cultural competency training has been proposed to assist with reducing racial and ethnic health disparities and meeting the needs of the diverse patient populations (Aggarwal et al., 2016b). The instruction interventions introduced in cultural competency training impact clinician adherence. In serving a diverse patient population, the understanding and acknowledgment of ethnicity, race, and culture sit at the center of cultural competency training (DelVecchio Good & Hannah, 2015). This paper presents a brief understanding of the psychiatric residents' perceptions of their cultural competency training and the importance of cross-cultural care in delivering quality culturally responsive mental health care to a diverse patient population at a NYC public hospital.

A review of the literature regarding program enhancements provided insight that healthcare staff acknowledges the importance of culturally responsive training in healthcare. The upgrades include the importance of involving community religious leaders, training in language immersion in the treatment of limited English proficiency (LEP) patients, and consistent program evaluation and assessments of residents' competency. These program recommendations are intended for the resident training

director, the director of psychiatry, director of information technology (IT) and the director of language services regarding the implementation of the targeted program enhancements in the cultural competency training of psychiatric residents.

The program enhancements will be presented to assist in the discussion and implementation of upgrading the current psychiatric residency training in cultural competency. Recommended steps will guide the review and implementation of the augmented curriculum in the practice of cultural issues, the implementation of new language immersion training, and the involvement of community religious leaders in enhancing residents' knowledge and delivery of culturally responsive mental health care. Through the implementation of suggested program enhancements in this white paper, psychiatric resident training may improve psychiatric residents' cultural competency and their ability to meet patient needs in the delivery of culturally responsive mental health care.

This paper can be used to contribute to research on cultural competence training in mental health care and to examine cross-cultural relationships between patients and providers; additionally, it may lead to improved clinician perceptions of cultural competency training by psychiatric residents.

Background

This white paper is the result of a research study conducted at a public hospital in NYC that examined the perceptions of psychiatric residents about their cultural competency training in the delivery of culturally responsive mental health care. The goal

of the study was to identify effective cultural competency training practices identified by psychiatric residents that assist in delivering quality mental health care.

The research study included eight third and fourth-year psychiatric residents, each of whom was currently enrolled in the psychiatric residency training program. The methodology used was a qualitative case study, and the data collection occurred via a focus group interview and a review of current program training materials. The social implications for studying the training of psychiatric residents in cultural competency indicates cultural competency training for psychiatrists providing mental health care to minority patients is relevant and necessary for psychiatrists to become sensitive, non-discriminative, and responsive to the psychiatric needs of minority patients.

Problem under Study

Background

In 2013, the study site conducted and published a CHNA (community health needs assessment) with ambulatory care patients, providers, and community stakeholders. The purpose of this inquiry was to determine the hospitals' effectiveness in the delivery of its health care services to their culturally diverse patient population. The assessment was conducted to report in-depth community health needs, to prioritize healthcare issues based on the responses, and address and develop culturally and linguistically appropriate programs and services to meet the complex medical and social needs of the study site's patient population .

Three focus groups were conducted that included (a) facility patients, (b) a group comprised of healthcare providers, and (c) community stakeholders, including residents

and representatives of community-based organizations. The identified participants answered several questions related to the delivery of healthcare at the study site . Although ranked differently among each group, the participants identified heart disease, diabetes, hypertension, obesity, and mental illness as primary health concerns of the health care consumers of the study site. The outcome of the 2013 CHNA conducted at the study site established the foundation for this study by providing an insight into what community stakeholders, health care providers, and patients want and need to receive culturally competent quality health care.

In 2019, the CHNA echoed the 2013 and 2016 sentiments of the residents and reported the daily challenges of poverty, violence, and poor living conditions continue to affect the physical and mental health of Harlem residents (New York City Health+Hospitals, 2019). In 2019, mental illness continued to rank within the top five challenges faced by the residents in the study site community (New York City Health + Hospitals, 2019). The overview of these community assessments highlighted not only the services provided to the study site's patients but also the challenge of the diversity that exists among patients, providers, and community stakeholders.

The CHNAs ranked mental illness as a health need by all identified participants, thereby suggesting a closer investigation of the cultural differences between patients and providers and the delivery of mental health services. DelVecchio-Good and Hannah (2015) indicated mental illness contributes to a significant role in the health and well-being of individuals and communities in the United States and the world. According to a CHNA, mental health care is listed as the third-largest ambulatory care service at the

study site, providing mental health services to approximately 42,000 study site consumers in 2016 . Of the 13 community health needs identified, mental illness was ranked sixth among the study site's community (New York City Health +Hospitals, 2016).

The study site is a mental health care provider and is among the ambulatory services provided at the study site. The study site serves as a teaching institution utilizing second-year psychiatric residents as the primary mental health providers who deliver outpatient services. To provide culturally sensitive mental health care needs of the study site population, the second-year psychiatric residents participate in cultural competency training. The study site's 2013 CHNA was used to surveyed participants who noted that a cultural difference existed between the mental health providers and their patient population. The problem that informs this study originates from the outcomes of the 2013 CHNA focus groups that suggested establishing appropriate cultural services, providing better patient relationships, and practitioners' satisfaction with training. This investigation reviewed the cultural competency training strategies at the study site, specifically the perceptions of the psychiatric residents about their medical education in cultural competency. The purpose of the research was to understand the perspectives of a culturally diverse group of psychiatric residents concerning their cultural competency training with the foresight to improve future cultural competency training in meeting the health care needs of the culturally diverse patient population of the study site.

Local Problem

Understanding the problem requires a description of the institution, staff, and patient population. The study site is a 286-bed urban municipal community-based

hospital that provides a broad array of preventive, primary, and acute care services, including acute inpatient and outpatient psychiatric and substance abuse services. A profile of the communities served by the study site indicated the majority of patients were at or below the poverty line. Between 40 to 60% of the residents in the communities served by the study site receive some public income support. The 2013 CHNA reported that financial support included cash assistance, temporary assistance to needy families, supplemental security income, and Medicaid.

The responses from health care practitioners are of particular importance because the doctor/patient relationship influences patient engagement. Green et al. (2017) suggested that a patient-centered perspective improves the quality of care, healthcare, and health outcomes. Knecht, Fontana, Fisher, Spitz, and Tetreault (2019) substantiated this claim and reported the importance of establishing a strong therapeutic alliance across cultural lines that promotes participant engagement in cross-cultural experiences. The authors stressed cultural knowledge requires some degree of immersion and an open and trusting relationship so patients can express themselves. The therapeutic relationship is most at risk when practitioners demonstrate low levels of cultural competency. Therefore, the goal of medical training programs, among mental health providers, should include cultural competency training in the delivery of culturally responsive psychotherapy. Cultural competence describes a set of practices, attitudes, and procedures that enable agencies, organizations, and health care professionals to interact with other cultures (DeSilva, Aggarwal, Lewis-Fernandez, 2015; Jackson, 2015). Components of cultural

competence include cross-cultural skills, a personal worldview of one's culture, and knowledge and a review of other cultural practices (Jackson, 2015).

In the study site's psychiatry residency training program, cultural competency training evolved by utilizing the DSM-5 Cultural Formulation Interview. This evidence-based tool is composed of a series of questionnaires to assist clinicians with making person-centered cultural assessments in the psychiatric diagnosis and treatment of a culturally diverse population. (DeSilva et al., 2015). This training tool uses the DSM-5 definition of culture, which states that culture refers to systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations. The outcomes of study site's CHNA, coupled with the importance of being able to communicate effectively with its diverse population, highlighted a need for cultural proficiency.

In health care, cultural proficiency is vital for communicating with patients and their families in the delivery of culturally responsive healthcare. Therefore, the study is developed to understand the perspectives of the psychiatric residents in their medical training in cultural competency. The results of the study will not only be meaningful to the patients, but also the psychiatric residency training program, and the psychiatric residents in the delivery of culturally appropriate mental health care services at the study site.

Findings and Recommendations

The shared experiences of the psychiatric residents participating in cultural competency training in their residency program addressed the central question guiding this study which was: "How do psychiatry residents perceive the impact of their cultural

competency training in the delivery of culturally appropriate mental health care?" The two sub-questions were: "How do psychiatry residents perceive the value of cultural competency training in the provision of culturally sensitive mental health care?" and "How do psychiatry residents perceive their current medical training in cultural competency concerning their careers in culturally different communities?"

The residents favorably rated their current training in cultural competency and described their training as necessary in the delivery of culturally responsive mental healthcare. Their discussion of cultural competency indicated improving the comfortability of residents in delivering culturally sensitive mental health care, computer-based learning as a preference, the importance of job training, best practices, and preferences in cultural competency training. Essential to the residents in their cultural competency training was bridging the cultural divide between them and the population they serve. To develop this therapeutic alliance in the delivery of quality mental healthcare, the residents suggested training in culture, involvement with community religious leaders, and language familiarity.

Finding 1: The residents want confidence in interacting with different races/ethnicity to understand their patients' cultural backgrounds.

Recommendation: Integrate an evidence-based curriculum that builds upon cultural understanding.

The residents suggested the involvement of community leaders would be helpful in patient engagement. Resident 2 suggested, "Get the religious leaders, like the minister,

the Imam, to come and speak to us (residents) to give us their perspective about how to talk to patients from a different culture who are more conservative."

Although best training practices vary in the literature, the impact of cultural factors is acknowledged and remains central in developing successful cultural competency training interventions (Aggarwal et al., 2016; DelVecchio Good & Hannah, 2015). Conflicts between providers and patients exist when clinicians are not aware of the culture of their patient population. The cultural competency training sets the foundation to develop clinician skills that can be employed to understand the cultural values of their culturally diverse patient populations.

In response to the immigrant migration and the growing social and psychiatric needs of these patients, Schoyler-Ocak et al. (2015) studied the European Psychiatric Association's [EPA] expert views on critical issues related to cultural competence training to guide the subject matter. The research proposed psychiatrists learned to see patients in their cultural context, as well as considering their cultural values and prejudices in treating a cross-cultural patient population. Scholyer-Ocak et al. (2015) emphasized that psychiatrists are authorities in biomedicine; patients are authorities in their personal knowledge of anguish… scientific encounters should be viewed as a reciprocal learning opportunities.

Therefore, the addition of evidence-based practices that integrate and build upon cultural understanding would be beneficial to the current cultural competency training modules. The findings from the studies concluded incorporating the knowledge of culture in medical training set the precedent to provide culturally responsive mental healthcare to

a diverse patient population. Therefore, the program administrators must take the lead in providing additional training to implement culture into the competency medical training for psychiatric residents (DelVecchio Good & Hannah, 2015; Scholyer-Ocak et al. 2015).

For multicultural competence to result in sensitivity and respect for clients' differences, values, beliefs, and practices, inclusion of the integration of specific religious and spiritual interventions are needed in cultural competency training. Barnett (2016) recommended developing and maintaining ongoing relationships with religious leaders or other experts on various faith traditions in the local communities. The suggested implementation of these professional relationships will not only be helpful in aspirational efforts to provide clients with the most appropriate and useful care possible but also serve as consultants and useful referral resources when a client's needs are more appropriately met through religious or spiritual consultation or in addition to psychotherapy in mental health treatment (Barnett, 2016). Developing a group of committed community religious leaders who will participate in the cultural competency training of psychiatric residents by providing spiritual and religious insight can yield greater access and understanding in developing culturally responsive mental healthcare.

Finding 2: The residents' concerns about the availability of live interpreters were reported as being burdensome.

Recommendation: Advancing residents' training with people with limited English proficiency (LEP) in their cultural competency training.

Roberts (2013) defined people with LEP as anyone above the age of five who reports speaking English less than "very well." Immigration to the United States results in

a higher prevalence of depression among immigrants and refugees compared to the general population (Njeru et al., 2016). Immigrants are less likely to obtain mental health services and treatment, and they receive less than standard medical treatment and care when sought by these individuals (Njeru et al., 2016). The lack of interpreter services exacerbates this barrier, and optimizing the utilization of mental health services would require addressing LEP (Njeru et al., 2016). To maximize use among LEP patients, incorporating elements that improve healthcare access such as community engagement and incorporating language-congruent community health workers is paramount. Doing so would enhance cultural competency and responsiveness within healthcare systems to help with patient engagement across the care continuum of culturally diverse patients and those who are LEP.

With health disparities posing the greatest threat to culturally diverse populations, and few residency programs incorporating LEP, this study reiterates the need to integrate LEP training in the cultural competency training for residents at the study site. Implementing LEP training would build upon what is necessary and desired by the culturally diverse patient populations and the residency program, respectively. Implementation of this initiative will serve as cutting edge cultural competency training for psychiatric residents.

Ivers and Villalba's (2015) research examined the effect of bilingualism on counseling students' multicultural counseling competence among 178 masters-level multicultural counseling students. Culture and language are interconnected; learning a second language might facilitate multicultural counseling development and benefit in the

delivery of quality counseling services for non-English speaking clients (Ivers & Villalba, 2015). The findings of this study support bilingual counselor training programs and suggested adding concerns about culture and language as a feature of their educational plan preparing (Ivers & Villalba, 2015). Bilingualism positively influences multicultural awareness and knowledge. Knowing this information could be responsible and reasonable for providing additional language training opportunities to students, such as second-language training courses (Ivers & Villalba, 2015). The implications of this study suggest that the addition of second-language training could not only enhance access to counseling for LEP patients but enhance counselors' multicultural counseling knowledge and awareness, thus, establishing cultural and linguistic skills necessary to effectively serve the increasingly LEP patient population.

Empirical data indicate that 13.1% of the United States population speaks Spanish, and 41.6% of the Spanish speakers reported speaking English less than well (Aitken, 2019). Aitken (2019) reported LEP patients often deferred needed medical attention because of the language barriers, and the use of interpreters who have received training and certification as a means to improve healthcare for patients with LEP suggested. Aitkin indicated there is a shortage of trained interpreters nationwide, which disproportionately impacts free clinics where a majority of LEP patients receive care.

According to Aitkin (2019), the introduction and implementation of the Loyola University Chicago Stritch School of Medicine nine-hour course in interpreting techniques and language skills to bilingual first- and second-year medical students fill the gap in the absence of certified medical interpreters. Aitkin reported that trained medical

students not only increased the self-perceived interpreter efficacy but also patient and physician satisfaction. The participation of medical students in interpreter certification training could be provided as a benefit by increasing in-person interpreter availability, providing second language acquisition skills, and producing well-trained, culturally competent Spanish-speaking clinicians who can meet the linguistic needs of LEP patients. The implementation of this type of program enhancement could be applied with minimal effort and offer a significant benefit to the current residency training program in the treatment of LEP patients.

Finding 3: A lack of program evaluation in the residency training program.

Recommendation: Implement a valid and effective assessment tool to enhance the review of the impact of the current training program and provide annual feedback to the residency training director.

The implementation of a valid, evidence-based assessment tool enhances the evaluation of the current training program and provides the residency training director with feedback from residents. This recommendation has been supported in recent studies and suggests implementation of evaluation can improve planning of cultural competency training (Cardinal et al., 2016, & Jongen, McCalman, Bainbridge (2017). In a systematic literature review on cultural competence interventions in health care in Canada, the United States, Australia, and New Zealand, Jongen, et al., (2017) reviewed 64 studies on cultural competency interventions. The review highlighted support for systematic program evaluation of cultural competency services. The endorsement and

implementation of program evaluations improve outcomes in satisfaction levels, service utilization, and essential indicators of cultural competency training intervention services.

In 2018, Jongen et al. continued their research and conducted a literature review of cultural competency programs focusing specifically on health care workforce interventions. This study substantiates the need for program evaluation to learn if the implemented program enhancements imparted skills to the residents in the cultural competency residency training program. The study concluded that there is a need for consistent evaluation approaches to contribute to evidence-based interventions and applications of knowledge, attitudes, and skills that impact practitioner behaviors in cultural competency training.

Cardinal et al., (2016) conducted a study by using a confidential survey with residency program directors, and they sought to understand the efforts of internal medicine to meet the accreditation requirements for cultural competency medical education. This data supports the need for valid and effective assessment tools in these areas. Cardinal et al. recommended a review of Kern's six steps for curricular development as a model of what constitutes a culturally competent physician training program with an evaluation and feedback. The recommendation for an evaluation tool is not only to determine the implementation of cultural competency training but to evaluate and measure the skills and preparedness of the residents to deliver culturally responsive mental health care.

Green et al. (2017) developed the Cross-Cultural Care Survey (CCCS) to assess self-perceived skills and preparedness to deliver cross-cultural care among the residents

and to evaluate the learning environment at their institution. The CCCS was found to be a valuable longitudinal assessment tool that could be applied to determine medical students' perceived preparedness and skillfulness to care for culturally diverse patient populations. The CCCS was also found to be an excellent curricular assessment tool to help guide curricular enhancement in cultural competency and track individual residents' perceived cultural competency.

The recommendation of program evaluation will not only benefit the residency director in implementing evidence-based training practices, but also measure the residents' needs and ability to deliver culturally competent mental health care. The implementation of Kern's six step curricular development model components is noted to be generalizable, beneficial, and applicable for the evaluation of residency training programs. Therefore, it is recommended that the residency training director conduct a blend of the suggested evidence-based assessments including: (a) Kern's six steps to measure curricular development; (b) psychodynamic training in cultural psychiatry; (c) the language immersion training to assist in developing the cultural competency training and increasing the potential for additional trained interpreters for the LEP patients; and (d) the CCPS to assess self-perceived skills and preparedness to deliver cross-cultural care among the residents, and to create and implement a useful cultural competency training evaluation.

Suggested Timeline

January 2020: Residency director will present and discuss the implementation of the program enhancements with the residency training committee at the study site.

February 2020: Residency director will introduce:

- Program enhancements to IT director to develop and implement the computer-based training modules and computer-based evaluation, and assessment tools.
- Program enhancements to the director of language services to assist in the implementation of the language immersion training.
- Meet with training facilitators to develop and implement the culture initiative, religious leader involvement, program evaluation program, and assessment.

March 2020: Resident director, director of IT and director of language services implement schedules for identified curriculums

April 2020: Introduce training facilitators to program enhancements, curricula with new program timelines.

May 2020: Conduct lessons in program enhancements in psychodynamic cultural psychiatry, language immersion training, religious intervention, implement new evaluation tools Cultural Competency Preparedness Survey (CCPS), and Kerns' six steps

June 2020: Resident director review outcomes of CCPS evaluation tools on the Kern's six steps instruction, psychodynamic cultural psychiatry instruction, religious leaders intervention, and interpreter training and language immersion and shares with the residency training committee of study site and uses data to review and revise psychiatric resident training program for implementation in the 2020- 2021 resident training year.

July 2020: Full implementation of recommendations of the suggested program to the psychiatric residency training director.

Conclusion

Cultural competency is at the center of good clinical practice. To be effective in integrating cultural competency training that meets both the needs of the residents and patients requires integrating diversity and inclusion into the instruction through a variety of pedagogical and systemic methods. Combining an understanding of the diverse patient's culture, language differences, and community must be weaved into the cultural competency clinical training. Combining the various elements and pedagogies in cultural competency training into a flexible online format will assist in meeting the needs of the residents with different learning styles. Central to building systematic and sustainable changes is the engagement of the residents, but also the community, the stakeholders, and policymakers.

The integration of both formal and informal feedback from residents through course evaluations will provide positive or negative commentaries on the value and relevancy of the curriculum and training in cultural competency. The inclusion of advanced program enhancements in the cultural competency training program will prepare future culturally trained psychiatric residents to deliver culturally responsive mental healthcare.

The role of the residency training director will be to improve cultural competency skills and cross-culture education for all residents. Through the development of course content, course strategies, and pedagogy, the goal will be to promote diversity awareness, resident engagement, inclusiveness, and a reflective summary of the program. Lastly, it is essential to note the resident training directors will require support and resources in the

development, implementation, and successful management of improving cultural competency training for psychiatric residents.

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Appendix B: Participant Demographics Survey

1. **What is your gender?**
   - ○ Female
   - ○ Male
   - ○ Other (specify)

2. **Which category below includes your age?**
   - ○ **17 or younger**
   - ○ **18-20**
   - ○ **21-29**
   - ○ **30-39**
   - ○ **40-49**
   - ○ **50-59**
   - ○ **60 or older**

3. **Please specify what your current Year is in the Residency Program?**
   - ○ **PGY 1**
   - ○ **PGY 2**
   - ○ **PGY 3**
   - ○ **PGY 4**
   - ○ **Other**

4. **Marital Status: What is your Marital Status?**
   - ○ **Single never married**
   - ○ **Married or domestic partner**
   - ○ **Widowed**
   - ○ **Divorced**
   - ○ **Separated**
   - ○ **Prefer not to answer**

5. **Ethnicity Origin or Race: Please specify your ethnicity**
   - ○ White
   - ○ Black or African-American
   - ○ Hispanic or Latino
   - ○ American Indian or Alaskan Native
   - ○ Some other race (please specify)
   - ○ Asian
   - ○ Native Hawaiian or other Pacific Islander
   - ○ From multiple races

Appendix C: Interview Protocol

Introduction:

Good evening. My name is Carol Matthews; I am a doctoral candidate at Walden University in the school of education. Thank you for coming. You have been selected to speak with us today because you have been identified as second-year Psychiatric Residents who have participated in cultural competency training here at HHC. Therefore, please share your perceptions of the following questions about your medical training in cultural competency at HHC. There are no right or wrong or desirable or undesirable answers. I would like you to feel comfortable with saying what you really think and how you feel. All your responses are confidential. Like in Las Vegas, "What happens in this room stays in this room."

My research project as a whole, focuses on medical training in cultural competency, with a particular interest in understanding how psychiatric residents are engaged in this training, residents' perceptions of their training in cultural competency, and begin to share what psychiatric residents need to deliver culturally responsive health care to the diverse patient population here at HHC.

My study does not aim to evaluate your techniques or experiences. Instead, I am trying to learn more about what are your perceptions of your training in cultural competency, and hopefully learn how the Psychiatric Residency Training program can help improve residents' learning of cultural competency.

Tape Recorder Instructions:

To facilitate note-taking, I would like to audiotape our conversations today. In addition to the audiotape, I would like to introduce you to my assistant, _____ who will take notes while we discuss your perceptions of the training in cultural competency here at HHC. The purpose of this is so that I can get all the details but, at the same time, be able to carry on an attentive conversation with you. These tapes will be used to collect and analyze your responses. Only researchers on the project will have access to the recordings, which will be destroyed after they are transcribed.

Consent Form Instructions:

Please sign the informed consent form. This form is devised to meet our human subject requirements. Essentially, this document states that: (1) all information will be held confidential, (2) your participation is voluntary, and you may stop at any time if you feel uncomfortable, and (3) we do not intend to inflict any harm. Thank you for agreeing to participate.

We have planned this interview to last no longer than 90 minutes. During this time, we have several questions that we would like to cover. If time begins to run short, it may be necessary to interrupt you to push ahead and complete this line of questioning.

ICE BREAKER:

Tell us something about yourself we would not know just by looking at you?

Interview Questions:

1. Please state your name, and where you attended medical school.
2. Since participating in the cultural competency training session(s) of the study site Psychiatric Residency Training program, please tell us about your understanding of cultural competency?
3. Cultural competency training is just one competent in your medical training. Can you talk to us about your perceptions of training in cultural competency at study site in the Psychiatric Residency Training Program?
4. Cultural competency training is provided to assist in the delivery of mental health care to a diverse patient population at HHC. Do you perceive that the training is accomplishing what you hoped it might?
5. If you could develop an ideal medical training in cultural competency, what would be included to meet your needs in treating the diverse patient populations of HHC? What might you exclude?
6. How do you perceive cultural competency concerning your careers in culturally different communities?
7. What are your perceptions of the patients? Do you feel they are comfortable with your ability to relate to them? Or do they seem to feel you do not or cannot relate to them?

Member Checking

Once the group interview has been transcribed, I will contact you to share a copy of the transcript. You will have an opportunity to review the document for accuracy (member check), to ensure what you have shared was transcribed correctly, and to approve the transcription.

I would like to thank you for your participation in this discussion.

Appendix D: Psychiatry Resident Enhanced Cultural Competency Participation Posttest

1. Briefly describe your experience participating in the enhanced cultural competency training in culture?
2. How did your experience increase cross-cultural communication with culturally diverse patients?
3. How did your experience in the enhanced cultural competency training impact your multicultural competence?
4. Could the teachings of cross-cultural communication assist you in accommodating diverse patient needs?
5. How did your experience in cross-cultural communication and cultural diversity training compare to the previous exercises?

Appendix E: Religious Leaders in Cultural Competency Training Survey

1. How important is the inclusion of religious/spiritual beliefs when providing mental healthcare?

   1 2 3 4 5

2. Did the Program Enhancements, inclusion of religious leaders, in your cultural competency training prepare you to understand your patient's understanding of God or a higher power?

   1 2 3 4 5

3. Did the Program Enhancements, inclusion of religious leaders, in your cultural competency training prepare you to understand your patient's understanding of prayer as a therapeutic intervention?

   1 2 3 4 5

4. Did the inclusion of religious leaders in cultural competency training prepare you to understand their religious beliefs can influence your patient's coping abilities?

   1 2 3 4 5

5. Did the Program Enhancements, inclusion of religious leaders, in cultural competency training prepare you to understand determining a patient's spiritual functioning is important in delivering quality mental healthcare?

   1 2 3 4 5

1= *Not at All Useful*, 2= *Somewhat Useful*, 3= *Useful,* 4= *Very Useful* and 5 =*N/A*

Appendix F: Program Enhancements Cultural Competency Preparedness Survey (CCPS)

1= *Not at All Useful*, 2= *Somewhat Useful*, 3= *Useful,* 4= *Very Useful* and 5 =*N/A*

Preparedness:

1. The Program Enhancements prepared me to treat patients with Limited English Proficiency?
   1 2 3 4 5

2. The Program Enhancements prepared me to treat patients from cultures different from your own?
   1 2 3 4 5

3. The Program Enhancements prepared me to treat patients who are members of racial/ethnic backgrounds different from my own?
   1 2 3 4 5

4. The Program Enhancements prepared me to treat patients with health beliefs or practices which disagree with traditional Western medicine?
   1 2 3 4 5

5. The Program Enhancements prepared me to treat patients whose religious beliefs may interfere with mental health treatment?
   1 2 3 4 5

6. The Program Enhancements prepared me to treat new immigrants?
   1 2 3 4 5

Skillfulness:

1. Did the Program Enhancements provide you with the skills needed to assess a patient's understanding of the causes of his or her mental illness?
   1 2 3 4 5

2. Did the Program Enhancements provide you with the skills needed in working effectively with limited English proficient patients?
   1 2 3 4 5

3. Did the Program Enhancements provide you with the skills needed in negotiating with the patient aspects of their treatment plan?
   1 2 3 4 5

4. Did the Program Enhancements provide you with skills needed in identifying religious beliefs that might affect mental healthcare?
   1 2 3 4 5

5. Did the Program Enhancements provide you with skills needed in identifying cultural customs that might affect mental healthcare?
   1 2 3 4 5