special articles

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PARIMALA MOODLEY

Building a culturally capable workforce – an educational approach to delivering equitable mental health services

A working group was brought together in a 2-day workshop by the Sub-Dean to take forward training in transcultural psychiatry. The group comprised senior members of the College; psychiatrists with particular expertise in transcultural issues and/or education; and included trainers from undergraduate to continuing professional development (CPD) level.

The participants were: Dr P. Moodley (Sub-Dean and Chair, Transcultural Special Interest Group); Dr D. K. M. L. Bhugra (Chair Overseas Doctors Training Committee): Dr K. S. Bhui; Dr A. S. Bird (Chair, Psychiatric Tutors Committee); Dr P. C. W. Bowie; Professor J. L. Cox (President); Dr L. Dratcu; Dr S. J. M. Fernando; Dr P. D. J. Hettiaratchy; Dr S. Jadhav; Professor C. L. E. Katona (Dean); Dr A. J. Kent; Dr D. I. Khoosal; Dr F. R. Margison; Dr K. J. McKenzie; Professor O. A. Oyebode (Deputy Chief Examiner); Dr R. Ramana; Dr T. E. Sensky; and Professor R. J. W. Williams.

Over the 2 days, the group defined a culturally sensitive psychiatrist in terms of requisite knowledge, skills and ability; made specific recommendations on the current draft of the basic specialist training curriculum; made recommendations for what should be taught at different levels of training, i.e. undergraduate to postgraduate training, and considered how this material should be taught and examined and worked out, the process by which this would be taken forward through the College's educational structures and to all trainers.

A culturally capable doctor was defined as one who is able to carry out an appropriate and sensitive assessment and determine a management plan that is pertinent to the particular patient, irrespective of the patient or the doctor's background. Cultural differences are not just those obvious differences often perceived in 'visible' minorities, but also those less obvious but equally important differences such as those between the English and the Welsh.

The knowledge skills and attitudes of a well-trained and culturally competent psychiatrist, are described below.

Knowledge

It is necessary to have a broad-based knowledge of the construction of psychiatry and psychiatric diagnoses and the cultures of psychiatry and psychology as we learn and teach them. There are other health belief systems and other views about mental health and illness. In this respect an understanding of different notions of self and identity, including the manner in which they are constructed, is crucial. Conceptualisation of commonly used and controversial terminology such as race and racism, culture, ethnicity and stigma is essential. Different cultures have different rituals, rites of passage, taboos and idioms of distress. It is not possible to know all of these but it is necessary to recognise one's limitations.

It is necessary also to know about migration, acculturation and international affairs such as regional wars and conflicts, which may have significant impact on local demographics and need.

Every psychiatrist needs to know how organisations function, how institutional racism operates and how these may impact on access to services and pathways into care. Additionally, knowledge of local and national non-statutory organisations is essential. Knowledge of available evidence-based data on ethno-psychopharmacology and intercultural therapies, as applied to people of diverse backgrounds, is also necessary.

Skills

The skills required include the ability to orient to local cultural influences, to adapt to changing values and influences and to adapt services to local cultural needs. Additionally there is a need to relate meaningfully to people irrespective of cultural background and to have the self-confidence and the ability to deal effectively with racism. This means that the psychiatrist has to be able to live with ambiguity and to manage uncertainty while exploring other world views, working with interpreters and acquiring culturally specific knowledge. This requires very good negotiating skills as well as the ability to recognise the range of culturally sensitive influences. Professionalism has to be maintained irrespective of personal beliefs.

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special articles

Attitudes

Every clinician should have the humility to acknowledge his or her deficits and a willingness to use the uncertainty for creative learning and a change in practice. There should be a move away from the traditional; taking things for granted; stereotyping; tokenism and other historical legacies of 'missionary racism'; power imbalances, and the blaming culture, to a more open-minded, flexible, sensitive and constructive attitude to critical feedback and more reflective thinking.

Basic specialist training curriculum

The second task was to examine critically the basic specialist training curriculum and to suggest changes to incorporate training in transcultural matters.

Changes were made to various sections of the document and there were many overarching comments on the curriculum, which were not directly related to transcultural issues but the document as a whole. These have been forwarded to the Dean. It was agreed that there is a need in the document for a separate section on transcultural psychiatry. It was felt that this was necessary to encourage research into, and the development and valuation of, transcultural psychiatry.

Once this was successfully promoted then fragmentation could take place to promote integration. A separate section would force trainers to consider how they would train their juniors in this area and would give a clear message that the College takes this seriously. (c/f the introduction of the examination on the Critical Review Paper, which forced trainers and educational supervisors to learn very quickly!)

Teaching and examining

The next session was devoted to discussing how to teach, train and examine in order to ensure a culturally capable mental health workforce.

There was a recognition that people needed knowledge as well as skills. There was also a need to integrate theory and practice and to demonstrate application and relevance. Some issues are not specific to psychiatry and may be taught to medical students jointly with other departments, such as general practice. Incorporation into the basic specialist training curriculum and examinations will ensure that the trainees drive forward the training and their trainers. Tutors and educational supervisors would benefit from a training package as well as central workshops and the availability and access to colleagues with more experience in the field to facilitate joint training. A standard could be included in revalidation and clinical governance on this topic, and could also be incorporated into specialist registrar training.

A number of learning objectives were outlined with suggestions of how these could be taught, assessed and examined.

The knowledge-based learning objectives include an understanding of the terminology and conceptual framework within the discourse of race and culture. These encompass knowledge of local and national demographic profiles that would reflect service needs; the epidemiology, presentation, course and outcome of disorders across cultures; differing models of ethnic and racial identity; concepts of cultural diversity and theories of racism; differing meanings of health; illness including idioms of distress, help-seeking behaviour and stigmatising across different groups; and the contribution of social and medical sciences in cultural psychiatry. These knowledge-based objectives could be taught through self-directed learning, workshops, discussion groups, ward-based teaching and lectures. They could be examined through multiple choice questions, case reports, essays, dissertations, patient management problems, the individual patient assessments and the critical review paper.

In terms of the skills required, the learning objectives encompass awareness of how cultural factors influence presentations and assessment and management of cases; how doctors' culture may influence their clinical work; the ability to work with interpreters; the ability to understand and negotiate with the patients around their explanatory models; the ability to identify needs in a cultural formulation; and to apply knowledge of institutional discrimination to develop local services and to manage individual instances of racism. These skills would be taught through ward-based teaching, supervision, role plays, working with vignettes and evidence-based journal clubs. They could be examined using observed structured clinical examination (OSCE) stations at the individual patient assessment, patient management problems (PMPs) and through essays and the record of in-training assessment (RITA) process.

To develop the appropriate attitude to working with a diverse population, the learning objectives should include attention to and respect for the wishes, feelings and expectations of patients, relatives, carers and colleagues; openness to different styles of thinking and problem-solving; sensitivity to issues of racism and prejudice; and a willingness to question the basis of one's cultural assumptions and the impact of these on their professional practice. These learning objectives could be achieved through role-plays, supervision and the use of vignettes. They could be examined and/or assessed through the OSCEs, the PMPs, using trainee log books, using the RITA process and consultant appraisal through revalidation, and could be incorporated into the audit process and clinical governance.

The final task that the group applied themselves to was to determine how this process would be taken forward and cascaded through the college structures, to all trainers and trainees.

It was recognised that to facilitate the training there would be a need for a resource pack as well as a reading list. A subgroup will be working on the development of a resource pack, similar to that produced by the Clinical Psychology Race and Culture Special Interest Group.

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Additionally, trainers may need access to colleagues more experienced in this area, to carry out formal joint training sessions.

A paper will be submitted to the *Bulletin* and to the Court of Electors. Presentations will be made at annual meetings, regional meetings, the tutors committee and the CPD Committee. There will be a relevant inclusion into the next edition of *Good Psychiatric Practice*.

After many years of discussion and debate we now have specific and concrete plans to take the agenda forward and to ensure that we equip our workforce to deliver equitable services.

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special articles

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REX HAIGH

Therapeutic community research: past, present and future†

This paper gives an outline of four research areas examining therapeutic community practice: an international systematic review, health economics cost-offset work, a cross-institutional multi-level modelling outcome study and a proposed action research project to deliver continuous quality improvement in all British therapeutic communities. Results of the first two have been published and are summarised here; the third is under way and the fourth is seeking funding.

Therapeutic communities in mental health service settings date back to World War Two (Main, 1946; Kennard, 1999) and have a long history of research endeavour (Lees, 1999). However, most of the early work is descriptive or qualitative. A few contributions stand out, such as Robert Rapoport's *Community as Doctor*, which was published as a book in 1960 and described four 'themes' by which therapeutic communities have become known; permissiveness, reality confrontation, democratisation and communalism. The study used an ethnographic and questionnaire method at Henderson Hospital, and analysed the data using a grounded theory approach to distil the 'themes'.

In the past few years the Association of Therapeutic Communities (ATC) has formed a committee to co-ordinate research in a way that meets modern demands for high quality evidence (Department of Health, 1999), while keeping mindful of the democratic and consensual way in which therapeutic communities necessarily work. The studies discussed here have all been developed in consultation between therapeutic communities, in this committee. It does not include the extensive qualitative and quantitative research undertaken recently in prison units run as therapeutic communities (see for example, Marshall, 1997; Rawlings, 1998).

The international systematic review

A systematic international review was commissioned by the late High Security Psychiatric Services Commissioning Board (HSPSCB) in 1998 and published by the Centre for Reviews and Dissemination at York (Lees *et al*, 1999).

Their working definition of a therapeutic community was: "A consciously designed social environment and programme within a residential or day unit in which the social and group process is harnessed with therapeutic intent. In the therapeutic community the community is the primary therapeutic instrument." They did not attempt to address issues of defining personality disorder *per se*, noting that it was a term subject to sociological drift over the past 2–3 decades, over which time the studies reviewed were performed. Examples of figures from some of the units gave 87% of members meeting DSM–IV–R (American Psychiatric Association, 1987) criteria for borderline personality disorder (BPD), and 95% meeting criteria for at least one cluster B Axis II diagnosis; these are patient groups familiar to psychiatric and psychotherapy services.

In addition to research literature, they targeted the grey literature by writing to known therapeutic communities, writers and workers in the field, asking for any published and unpublished research they had and information about their principles, organisation and practices. The work was conducted in accordance with the guidelines from the Centre for Reviews and Dissemination – using protocols for searching and criteria for describing relevance and quality of identified research. Systematic meta-analysis was only possible for part of the results, as much of the literature was not numerically comparable.

They began with 8160 papers and reduced this to 294 broadly covering the relevant area. One hundred and eighty-one therapeutic communities were named in 38 countries. There were 113 items on outcome studies (72 in secure settings, including 20 addiction units). Of those 113, 52 were controlled: 10 randomised controlled trials (RCTs), 10 cross-institutional and 32 other controlled.

A meta-analysis was undertaken, with 23 controlled studies excluded because outcome criteria were unclear; raw numbers were not reported or original sample before attrition was not clearly specified. Where there was a choice of outcome measures or control groups emphasis was placed on conservative criteria (like reconviction rates rather than psychological improvements) and on non-treated controls.

†This paper was presented at the International Association of Group Psychotherapy in Jerusalem, 24 August 2000.

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