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EPA guidance on cultural competence training



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ABSTRACT

The stress of migration as well as social factors and changes related to the receiving society may lead to the manifestation of psychiatric disorders in vulnerable individuals after migration. The diversity of cultures, ethnicities, races and reasons for migration poses a challenge for those seeking to understand how illness is experienced by immigrants whose backgrounds differ significantly from their clinicians. Cultural competence represents good clinical practice and can be defined as such that a clinician regards each patient in the context of the patient's own culture as well as from the perspective of the clinician's cultural values and prejudices. The EPA Guidance on cultural competence training outlines some of the key issues related to cultural competence and how to deal with these. It points out that cultural competence represents a comprehensive response to the mental health care needs of immigrant patients and requires knowledge, skills and attitudes which can improve the effectiveness of psychiatric treatment. To reach these aims, both individual and organizational competence are needed, as well as teaching competence in terms of educational leadership. The WPA Guidance on Mental Health and Mental Health Care for Migrants and the EPA Guidance on Mental Health Care for Migrants list a series of recommendations for policy makers, service providers and clinicians; these are aimed at improving mental health care for immigrants. The authors of this paper would like to underline these recommendations and, focusing on cultural competency and training, believe that they will be of positive value.

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1. Introduction

With increasing globalization and movement of people across national boundaries it has become important that service providers are aware of the different needs of the patients they look after [100]. It is significantly likely that the stress of migration may contribute to the development of psychiatric disorders in vulnerable individuals. The onset of illness may occur soon after migration in some cases, whereas in other cases, mental health problems may develop over time as a result of the impact of social factors and changes related to the host society. Global migration

and the increasing number of immigrants to Europe imply that psychiatrists and patients may come from different cultures. The inclusion of cultural competence into psychiatric-psychotherapeutic training and practice is therefore a matter of growing relevance [2,6,8,12,16,23,27,28,39,50,57,62,91,111,112,126], just as “hyperdiversity” and migration are essentially global issues, but have a particular “local” shape nonetheless [68]. It is inevitable that in clinical settings, patients will present with differing clinical needs, and it has to be kept in mind that immigrants are a heterogeneous group in a number of ways [8,42,98].

Cultural competency represents good clinical practice with the goal that all patients, especially those from minority groups, feel acknowledged and supported. Similarly, when minority clinicians are not aware of the majority culture, conflicts may arise. Some minority communities are affected by the implications of migration despite having been born in the host country as the

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descendants of first generation immigrants. However, the needs of both minority patients and of minority psychiatrists are clinically relevant [56,76,82]. Whether or not a minority patient is a migrant, cultural competency training can be seen as beneficial for all clinicians [8,11,12,16,23,39,129]. Cultural competency is about skills that a clinician can employ to understand the cultural values, attitudes and behaviors of patients, especially those whose cultural background differs from that of the mental health professional [3,8,12,16,77,96]. It should also be noted that therapists who show multicultural competence receive higher ratings than therapists who do not show multicultural competence [121].

Mental health specialists regularly come into contact with patients from different cultural backgrounds, whose mental health is seriously affected by their immigration trajectory and/or the social conditions in which they live in the receiving country [40,77]. The wider social determinants of their health (including mental health) are often different from those of the settled community and may require health care professionals to use a different approach [8,12,16,56]. We know that culture plays an important role in the symptom presentation of distress and illness and, moreover, that cultural factors have quite an impact on the diagnostic process and the treatment strategies in all populations [3,39,77,101,108,122]. Cultural competence is one concept that has been advanced as a way of capturing the capacity to provide appropriate care for diverse patients, overcoming socio-cultural differences and other systemic challenges to reduce disparities with regard to mental health care provision [6,16,79,91,117,129]. Cultural competence is defined as the ability to understand and be aware of cultural factors in the therapeutic interaction between the therapist and the patient [6,8,13,39,71,111,112]. This should be applicable to all patients and therapeutic interactions [6,78,114]. Cultural competence includes an awareness of the impact of the psychiatrist's own ethno-cultural identity on his patients [62]. It is often erroneously assumed that only minority patients have cultures. All patients and staff are shaped by their own cultures with respect to ethnicity, religion, professional world etc., which can be very different from the patients' ones.

Cultural competency is not about learning the language or adopting the cultural values of a patient, but rather about respecting differences and making sure that these are bridgeable in order that they do not negatively impact upon the diagnostic and therapeutic process [51,79,96,97,116,127,129]. As rates of psychiatric disorders vary in different minority groups, it is vital that culturally sensitive psychiatric care is provided [1,7,8,25,52,77], e.g. psychotic disorders in ethnic minorities in different countries (UK, Denmark, Netherlands) [83,118]. For the purposes of this guidance paper, cultural competence is best understood as a process or even a sort of meta-theory rather than a specific attainable skill set.

The objective of this document is to outline cultural competence, which can serve as a basis for the development of training but also be of use to psychiatrists and psychotherapists [91]. The document begins with a short overview on migration and mental health, intercultural and institutional barriers, therapies for minority groups, and psychotherapy using interpreter. A detailed description of cultural competence, structured in the context of knowledge, skills, attitudes, and components of cultural competency follows. Specific training issues, and finally, our recommendations are pointed out.

In this Guidance Document, we outline some of the key issues related to cultural competence, and cultural competence training, and how to deal with these, with a focus on psychiatrists.

2. Development of the guidance document

The European Psychiatric Association decided to publish Guidance documents on a number of topics and this topic was

selected following discussions within the Guidance Committee. This Guidance document is based on current knowledge from existing policy documents issued by relevant bodies. Various international and European experts in the field were consulted. There are very few systematic reviews and the decision was made to gather opinions from experts who also contributed to the present paper. We deliberately chose to collect the views of these researchers and clinicians and not to conduct a systematic review. Next, we discussed these aspects and added the key issues related to cultural competence training based on our own expert knowledge, experience and good clinical practice to this guidance paper. The document was then circulated to the authors of the guidance paper for their comments and additions, which were amended accordingly. In addition, a literature search was conducted using electronic databases: all EBM reviews, EMBASE, Medline and PsychInfo. The search was performed using the terms "immigrants, ethnic minorities, refugee, asylum seeker, cultural, transcultural, cross-cultural, inter-cultural, mental health, psychiatry, training, competence, competence training" (Table 1). The inclusion criteria were: published in English, and specific for adult immigrants, ethnic minorities, refugees, and asylum seekers. It was decided not to use other languages for two reasons: firstly, as the main language of the EPA's activities is English. Second, it was not possible to gather accurate translations, which could be compared across countries at such short notice. The literature search resulted in 55 papers, which were subsequently reduced to 15 articles meeting the inclusion criteria (Table 1). These papers were screened, and due to constraints of space and since we were not carrying out a structured systematic review, we selected papers with meaningful results. Additionally, we looked at secondary references from key papers and gray literature was searched by hand using existing publications. We also checked the websites of several psychiatric organizations, especially focusing on English-speaking countries, to collect relevant information. The document was then circulated to the members of the EPA Guidance for their comments and was amended accordingly. Then the document was submitted to the EPA Board who approved it and their suggestions were taken into account.

3. Migration, minorities and mental health

It is well known that migration takes many forms, although it may be difficult to differentiate between forced and voluntary migration; both elements are often involved [8,74]. We do not propose to go into greater detail about migration and mental health in this document as an accompanying guidance paper on the mental health of immigrants covers these issues in depth [7]. It is well known that factors such as poverty, persecution or violence may play a role in migration. Within Europe there is an increase in immigration although this remains controversial and notions supporting migration are being challenged [93].

There are additional specific issues related to undocumented, illegal immigrants, asylum seekers or refugees [30,69,70,99]. The fragility of their existence raises additional issues about clinical management. It is estimated that about 15% of immigrants are undocumented [8,24]. Globally, the annual flow of immigrants between 2005 and 2010 was estimated to be around 2.7 million, with about 100 million immigrant workers in 2009 [125]. According to the Organization for Economic Co-operation and Development (OECD), the percentage of the foreign-born population within the European Community in 2008 ranged from 4% in Finland to 37% in Luxembourg, with an overall average of 8% [85,128]. According to Destatis, a German institution for epidemiological statistics, the number increased in 2013 to 44.5% in Luxembourg, with an overall average of 6.72% [33]. More than half

Table 1
Literature search - identified articles during the systematic review.

Used terms	Hits	Inclusion criteria: published in English, and specific for adult immigrants, ethnic minorities, refugees, and asylum seekers
<i>Search</i>		
Immigrants	15702	
Training psychiatry	41976	
Training psychiatry immigrants	155	
Cultural competence	6720	
Cultural competence training	4357	
Cultural competence training psychiatry	251	
Cultural competence training psychiatry immigrants	19	3 articles are not in English 1 article highlights cultural competence training in oncology 1 article research among nurses 1 article deals with family support 1 article is about Ernest Jones and the Isakowers 1 article is about qualitative research in emergency services ↓ 11 articles meet the inclusion criteria
<i>Search</i>		
Mental health	214053	
Mental health immigrants	1317	
Mental health immigrants psychiatry	403	
Mental health immigrants psychiatry cultural competence	23	
Mental health immigrants psychiatry cultural competence training	10	2 articles deal with children 1 article is in Danish ↓ 7 articles meet the inclusion criteria (all articles were detected also under "cultural competence training psychiatry immigrants")
<i>Search</i>		
Cross-cultural competence	1146	
Cross-cultural competence training	77	
Cross-cultural competence training psychiatry immigrants	5	1 article is in Danish 1 article deals with children 1 article addresses to nurses ↓ 2 articles meet the inclusion criteria (both were detected also under "cultural competence training psychiatry immigrants")
Cross-cultural competence training psychiatry refugees	3	1 article is not in English ↓ 2 articles were included (detected also under "cultural competence training psychiatry immigrants")
<i>Search</i>		
Transcultural competence	635	
Transcultural competence training	553	
Transcultural competence training psychiatry	19	1 article deals with qualitative research on psychosis 1 article is on treatment of refugees 1 article is about telepsychiatry 1 article deals with cultural formulation services 1 article is on case study method 1 article is about salutogenesis 3 articles deal with nursing 1 article is about leadership 1 article is not in English 1 article is a case report 1 article is on SOC and transcultural competence 1 article is on cultural consultation services 1 article is on contemporary psychiatric training ↓ 4 articles were included (3 of them were detected also under "cultural competence training psychiatry immigrants")
<i>Search</i>		
Ethnic minorities	12179	
Ethnic minorities psychiatry	798	
Ethnic minorities psychiatry cultural competence	16	
Ethnic minorities psychiatry cultural competence training	8	1 articles focuses on nurses 1 article deals with children 1 article deals with depression ↓ 5 articles were included (2 of them were detected also under "cultural competence training psychiatry immigrants")
<i>Search</i>		
Intercultural competence	89	
Intercultural competence training	68	1 article is on international partnership

Table 1 (Continued)

Used terms	Hits	Inclusion criteria: published in English, and specific for adult immigrants, ethnic minorities, refugees, and asylum seekers
Intercultural competence training immigrants	9	1 article is not in English 1 article deals with school students 1 article deals with physicians and students 1 article deals with children and adolescents 1 article deals with nursing 1 article deals with work rehabilitation 2 articles meet the inclusion criteria (both were detected under "cultural competence training psychiatry immigrants")
Sum of the papers	55	15 articles meet the inclusion criteria

a million asylum seekers and refugees arrived 2013 in Europe. Most of them came from different crises areas of the world with different cultural issues [113]. Of course, it is important to know from which part of the world the asylum seekers and refugees come, whether they are Western-immigrants or non-Western immigrants. Clearly, global mental health training is becoming more and more important [55,115]. Sandhu et al. (2013) highlighted specific challenges to treating immigrants in mental health services across all 16 countries; these include complications with diagnosis, difficulty in developing trust and the increased risk of marginalization [95]. Almost a third of the UK's and Spain's immigrants come from outside Europe [21], and although these immigrants are part of a new multicultural Europe, they are also beset by major physical and mental health concerns. Cultural influences on illness phenomenology, the role of language differences in clinical misunderstandings, and the complexities of culture and migration all have to be considered [48,53,78]. In any case, the explanatory models of the patients may vary from those of the psychiatrist as a function of factors such as migration, age, gender, experience, education and economic status [8,64,66,67], and this variation will affect therapeutic adherence and alliance. Cultural context and influences affect patients' and their families' understanding of the illness experience, but this may again change with acculturation [90,98]. One of the key lessons for psychiatrists, then, is to be aware of the acculturative processes.

Data on minorities' mental health is limited, e.g. data on addiction in immigrants [74]. There is a lack of epidemiological national studies on mental disorders, e.g. in Germany. Studies from other European countries found a greater risk for some mental disorders such as psychosis, dementia or suicidal behavior in immigrant groups [17,75,83,118,119]. An understanding of the background of immigrants is essential in order to effectively address health needs [76].

Migration involves a process of moving from one cultural and social setting to another for an extended period of time, and may well involve the loss of the familiar language (especially colloquial and dialect), attitudes, values, social structures and support networks. Eisenbruch has termed this loss "cultural bereavement" [37]. The loss may be particularly serious in minority groups if the available social support is not adequate. Cultural bereavement may be misdiagnosed because of linguistic and cultural misunderstandings, and because of the use of Western diagnostic criteria in non-Western people [7,8]. Stress in immigrant groups may be related to three arbitrary stages: pre-migration, migration and post-migration. Social factors including cultural bereavement, culture shock, a discrepancy between expectations and achievement, and acceptance by the new nation can all affect adjustment [7–9]. Further risk factors in new communities can include social exclusion, stigma and discrimination. Stigma and social exclusion commonly affect a person's recovery process as well as opportunities for societal participation [71].

The health status and health service usage of minority groups has not been well documented [92]. Improving this is critical and

should be regarded as a high priority [92]. Various studies have reported a higher risk of psychiatric disorders such as depression, anxiety, suicidal behavior and psychosis among immigrants [1,10,17,19,52,83,108,114,118,119]. Factors such as loneliness, homesickness, loss of status, language problems, resident permit status, unemployment, poverty, low education, poor living conditions, open racism and dissonance between norms and values of the country of origin and the receiving country, can all play an important role [8,13,14,36,42,98].

4. Intercultural and institutional barriers

In addition to the barriers already mentioned, another important barrier, especially for immigrants to Europe, is the lack of adequate legal entitlements [88]. Sometimes these barriers are mistakenly attributed to cultural differences and misunderstandings because the term 'culture' may be used as a putative politically correct expression reifying social differences and neglecting discrimination [47]. It is also helpful to recall that institutions have their own cultures which can produce barriers of various kinds, and minority groups may well face strong barriers to health care access [38,94,111,112]. Inequitable variation in the use and accessibility of health care services for immigrants, indigenous populations, and other minorities in EU countries remains a matter of concern for both health care providers and policy-makers; indeed, variations in health care usage between majority and minority populations have been noted [34]. Responsiveness to diversity is being recommended in European countries in order to improve access to care for minority populations as well as to improve the quality thereof [21,25,28,64,70,90]. A study conducted in Italy showed that immigrants' pathways to psychiatric services vary across cities. Social services were particularly important in referring immigrants to services providing culturally competent consultation-liaison activities [107]. Health care providers have both the obligation and the responsibility to ensure that all service users receive highest quality services according to their needs, irrespective of their background. According to Kirmayer et al. [60], the effects of globalization on increased flows of knowledge and the confrontation of different value systems heighten the importance of cultural psychiatry as a central pillar of clinical training. Kirmayer et al. [60] developed training methods using intensive case studies, education in pluralism, inter-institutional and inter-sectorial work, and fostering reflection on ethical issues. With the help of this clinical training, the usage of mental health care services by immigrant patients is hoped to increase.

De Jong [32] uses the term 'interculturalization' and defines it as the adaptation of mental health services to suit patients from different cultures. He developed a model to promote and assess interculturalization of mental health care services in Western multicultural societies. He suggested four contexts in which changes are necessary: the relationships between the immigrant patient and the health care workers and the treatment team; organizational adaptations required in the treatment context of

the mental health care facility; the relationship between the mental health facility and the ethnic communities; and the relationship between the mental health care system, other facilities and society at large [32]. This model is designed to negotiate the barriers mentioned above and increase the usage of the health care services.

5. Therapies for minority groups

The outcome of therapies in various settings is reported to be poor for minority groups. Inpatients of Turkish descent showed less positive conditions at the beginning of therapy (e.g. regarding primary education and professional training, duration of unemployment before beginning therapy, seeking pension) compared to German patients as well as a poorer treatment outcome. However, the proportion of immigrants among patients in psychiatric hospitals (17%) [98] is roughly similar to that of immigrants in the general population in Germany. The empirical evidence for the implementation of cultural adaptations in mental health interventions has been reviewed in two recent meta-analyses [12,44]. The four common methods of cultural adaptation as summarized by Griner and Smith [44] are worth mentioning. First, the cultural values of the immigrant patient should be incorporated into therapy. Second, immigrant patients can be paired with therapists of the same cultural or ethnic group. This is not always practical and although initial engagement may be good, the long-term outcomes of such a measure need further investigation. Third, mental health interventions should be easily accessible and targeted to immigrant patients' circumstances.

Forth, support resources available within an immigrant patient's community, extended family members, and tradition should all be incorporated into therapy interventions. The results of the meta-analytic review [44] indicate a moderate to strong benefit of culturally adapted interventions. They found that interventions targeted to a specific cultural group were four times more effective than interventions provided to groups consisting of patients from a variety of cultural backgrounds. Interventions conducted in patients' native or primary language were twice as effective as interventions conducted in English. Further, the results of additional analysis indicated that the format of intervention (individual therapy, group interventions) did not moderate the overall results [44]. In addition, the outcome of psychotherapy is influenced enormously by the diversity of concepts of illness and health, traditional values and beliefs as well as by specific cultural factors. Integrating two different cultures within the self is one of the most fundamental developmental tasks in the acculturative process.

Native language psychotherapy cannot be realized everywhere as the number of qualified psychotherapists who speak a native language is limited. Specialized concepts in which immigrants work with immigrants should be implemented if needed, but the authors of this guidance are in favour of integrated services in which psychiatrists work with all patients without categorizing them as immigrants or natives. This is with the aim of designing an inclusive treatment process, otherwise immigrants are excluded yet again or marginalized as patients. Therefore, the incorporation of psychologically trained interpreters or culture broker into the treatment process is of great importance, as it decreases the treatment gap of immigrant patients, especially the traumatized patients [97]. Alternatively, tele-psychiatry methods may be used to communicate with a therapist who speaks the language of the patient [130,131].

6. Psychotherapy using interpreters

The communication of distress in the face of language barriers can be a significant reason for non-engagement, increased levels of

dissatisfaction and dropout. As mentioned above, the idiom of distress in which patients communicate with psychiatrists can vary considerably from culture to culture [116]. We know that many languages do not have equivalent words to describe various mental disorders. For example, the word and notion of "depression" does not exist in all cultures, even though sadness, unhappiness and other symptoms can be described and verified. Presenting with somatic symptoms may delay diagnosis and treatment, and can carry with it the risk of unnecessary clinical investigations. Western psychiatrists often view patients presenting with somatoform symptoms as being psychologically inferior, which can subject them to unintended discrimination.

Effective communication between professionals and patients from different cultural origins and with differing language capacities is sometimes impossible without the help of interpreters or culture brokers. Therefore, psychiatrists and other mental health professionals should develop conceptual models, skills, and experience in conducting cross-language interviews using interpreters or culture brokers [124]. Language ability plays an essential role in immigrants' utilization of health care services. Language challenges can heighten systemic and socio-cultural barriers to accessing health information and resources. The provision of enhanced culturally and linguistically sensitive services may support immigrants in their care-giving role [22, 45]. Non-professional translators (family members, hospital staff members, etc.) can have a negative impact on medical treatment due to erroneous translation in the form of omissions, additions, or indeed changes to the initial message. Consequently, the use of professional interpreters or culture brokers is preferred. It has been shown that professional translation improves the quality of treatment and patients' satisfaction with treatment [5].

Providing high quality and sufficient interpreter services is critical in ensuring uptake of treatment options by affected individuals. There is no doubt that there is a profound danger in using diagnostic tools developed in different countries blindly without taking conceptual equivalence into account. This not only affects diagnostic patterns but also introduces what Kleinman calls 'category fallacy' [66,67]. In DSM-5, a major effort was made to recognize the influence of cultural factors on psychiatric symptoms and disease entities including the revision of the cultural formulation interview [35]. To be inclusive, health services must be geographically, emotionally and economically accessible, available, and affordable.

However, due to varying health care systems, some core principles must be agreed upon. Culture brokers or cultural mediators may provide an insight into different cultures and enable psychiatrists to provide better and more accessible services. Lie et al. [72] propose an algorithm to guide educators in designing and evaluating curricula with the aim of rigorously demonstrating the impact on patient outcomes and health disparities.

Hornberger et al. [51] noted that patients and clinicians preferred simultaneous interpretation, while interpreters or culture brokers showed a preference for the consecutive method. Tribe [110] describes four modes of interpreting: linguistic (word-for-word), psychotherapeutic or constructionist, health advocate/community interpreter or the bicultural work mode. It is helpful to know which model is being used and that the interpreters or culture brokers are conscious of this. Interpreters may also sometimes hold back information if they feel that sharing something may bring disrepute to the culture. Working with an interpreter or culture broker necessitates cultural competency and should therefore be trained.

7. Cultural competence

Cultural competence is necessary in clinical practice whereby the psychiatrist sees each patient in the context of the patient's

culture as well as their own cultural values and prejudices [7,8,9,10,77,80,100,111,112]. Psychiatrists are experts in biomedicine; patients are experts in their own experience of distress. Thus, clinical encounters should be viewed as two-way learning encounters. To achieve this goal, Carpenter-Song et al. [23] recommend that psychiatrists remain open and willing to seek clarification when presented with unusual or unfamiliar complaints. Nevertheless, resident physicians' self-reported preparedness to deliver cross-cultural care lags well behind preparedness in other clinical and technical areas [123].

Clinically competent mental health professionals are interested in the patient's cultural biases and world view, knowing that these are strongly colored by cultural values, and are also aware of their own personal cultural strengths, weaknesses and prejudices which may affect their response to patients [58,65,84,91,100,111,112,129]. Cultural competency constitutes cultural sensitivity, cultural empathy and cultural insight. Sensitivity means e.g. that clinicians must create an open and safe environment in which patients feel sufficiently comfortable to explore difficult and painful ideas and emotions [91]. A part of the training of cultural competence is the focus on providing psychiatrists an awareness of their own cultural identity and prejudices, their ability to question their own stereotypes, as well as their ability to show empathy across cultures [57,63]. Typically, psychiatrists acquire their knowledge through "bed side" training or inherit it from elder colleagues. Most of these psychiatrists have insight in the Western health systems. Cultural competence training may enable them to broaden their cultural horizon.

Cultural competence should be considered at both the individual/clinical level as well as at the institutional level [18,40,43,90,91,102,129].

Competent treatment of minority patients requires that mental health professionals are open to understanding the similarities and differences between more traditional and modern Western approaches [7,8,18,57,77,100,101,129]. It is important to understand and emphasize that cultural competence is not a static phenomenon but a developmental process, which represents a continuum [29,57]. It must be remembered that cultural competency should be tempered with what has been termed "cultural humility" [50,109]. Attaining a level of cultural proficiency indicates a level of cultural competence but this is not absolute and will need ongoing development.

On the other hand, institutional cultural competence requires not only the recognition of the barriers that exist to quality care at a systemic, organizational, and institutional level but also the elimination of these [6,16,40]. Some of these barriers are relatively straight forward, such as having insufficient professionals who speak the same language as the patient, lack of access to services via public transportation, restricted opening hours of a center, and so forth. Organizational cultural competence therefore necessitates appropriate changes [31,40,43,46,91,102]. Again, these principles must apply to all patients even though minority patients may have extra needs. Indeed, The National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care of the U.S. Department of Health and Human Services specify that centers must provide services in a linguistically accessible manner. Cultural competence at the level of the actual service can be understood to include efforts to make the community center more accessible and comfortable for minority patients through linguistically and culturally diverse staff [105].

To increase cultural competence, the systems need to value diversity, assess their own cultural values, be aware of cultural interactions, incorporate cultural knowledge, and adjust service delivery accordingly. Health systems should mark themselves on the cultural competency continuum [29,46,57]. Cultural competence also includes access to suitable and professionally trained

interpreters or culture brokers and a psychiatrist's ability to work with them. Cooperation with trained interpreters or bilingual professionals is of key importance but this may not always be possible due to limited resources. Another option is to use cultural mediators who can not only offer linguistic interpretation, but also mediate between health professionals and service users [93].

Learning objectives can be derived from the seven core competencies of a physician as defined by the Canadian Medical Education Directions for Specialists (CanMEDS) roles framework with the tripartite model of attitudes, knowledge, and skills [41,62]. These roles are defined as medical expert, communicator, scholar, professional, collaborator, manager and health advocate. In this guidance paper we address the medical experts, namely the psychiatrists. Kirmayer et al. [62] identified the following as core themes in a cultural psychiatry curriculum: culture and health, culture, illness and psychopathology, culture in clinical practice and culture and health care policy, services and systems. The learning objectives and teaching program must be adapted to the different psychiatric sub-specialty of cultural competence, which represents a comprehensive response to the mental health care needs of immigrant patients and requires knowledge, skills, and attitudes which can improve the effectiveness of psychiatric treatment [6,16,18,46,58,59,62,91].

8. Cultural knowledge

Cognitive cultural competence, otherwise known as "knowledge", involves awareness of the various ways in which culture, immigration status, and race impact psychosocial development, psychopathology, and therapeutic transactions. It is not always possible to be fully cognizant of all the cultures one aims to serve but in this day and age it is possible to get the correct information from multiple sources. However, it is important to be mindful of the risks of stereotyping and as such of losing sight of the specific patient [20,27,62,65,82,91,111,112].

9. Cultural skills

Knowledge by itself is abstracted from the actual clinical context and is insufficient for the development of an effective therapeutic interaction [39,77,106]. Technical competence or skills are essential in applying the knowledge in the clinical context. These key skills include a proficiency in intercultural communication, the capacity to develop a therapeutic relationship with a culturally different patient, and the ability to adapt diagnosis and treatment in response to cultural differences between the psychiatrist and the patient [7,8,57,62,91,111,112]. The psychiatrists must learn how to act in their roles as medical experts. These skills explore the awareness of differences – but also similarities – between cultures and their role in the expression and explanation of mental distress. The nature of human cognition and perception helps us to recognize the impact of cultural filters on both oneself and on others. This then forms the basis for a flexible response that is adaptable to the cultural context of the patient [77,91,106]. The cultural formulation of the DSM-5 offers a way of understanding the cultural context of a patient's experience of illness, this being essential for effective diagnostic assessment and clinical management. Using the Cultural Formulation Interview (CFI) of the DSM-5, psychiatrists may obtain information during the mental health assessment about the impact of culture on key aspects of the patient's clinical presentation and care. The questions refer to four domains of assessment: cultural definition of the problem, perceptions of cause, context and support, cultural factors affecting self-coping and past help seeking, and cultural factors affecting current help seeking [35]. The training to deal with the issues,

which are mentioned in the Cultural Formulation and learning to use the CFI can increase the cultural competence substantially in the clinical practice of psychiatrists. Understanding psychopathology and formulating psychiatric diagnosis in immigrants could be facilitated by a dimensional approach, more than by a categorical approach [17,86].

10. Cultural attitudes

Attitudes and beliefs which include personal prejudices will be affected by knowledge and will also affect behaviors [12,77,91]. Intercultural work requires psychiatrists to challenge their own perceptions of “reality”, explore their own cultural identity, prejudices and biases, and to be willing to adapt to distinct cultural practices.

One of the strongest critiques of the notion of cultural competence is that it is an attainable end product, a sort of technical expertise that confers on the individual a resolved accreditation that will enable them to work effectively with peoples from all cultures [27,58,91], which is learnable by cultural competence training.

11. Components of cultural competency

We do not aim to provide a full list of competencies since different models exist and have been discussed elsewhere [12,62,111,112]. These highlight various different aspects and the authors who developed this guidance document found that most of the work has been carried out in the USA and Canada.

11.1. For individuals

Cultural competence training must be presented to psychiatrists in the context of clinical practice and with organizational support if progress is to be made in decreasing ethnic disparities in care [117]. Cultural competency training can be provided by using cases and case note reviews, participant observation, cultural consultation where members of staff present cases and experts can advise them on specific cultural issues [87]. Interactive lectures and role play along with small group work can help staff understand the most effective ways of doing things and engaging patients. The key principles are related to clinical features such as listening carefully to the patient, eliciting the psychopathology in a culturally appropriate manner and assessing needs and suggesting changes in management while looking at the outcome. Reflective clinical practice is essential if these goals are to be achieved. Cultural knowledge will influence changes in attitudes and behaviors. Psychiatrists must acknowledge their own personal prejudices and try and deal with them. Avoiding assumptions and stereotyping to develop higher levels of empathy will produce better therapeutic engagement. Cultural empathy can transcend language barriers as most of the communication occurs at a non-verbal level. However, individual learning is not enough to guarantee a sensitive approach to diversity at the organizational level [16,26,62,111,112,117].

11.2. For organizations

Outcome indicators may be one way forward for measuring cultural sensitivity and cultural competency in an organization. Legal imperatives can lead to proper and prompt change especially when related to languages, monitoring for adherence and availability of culturally appropriate structures such as food, rooms for prayer and access to relevant cosmetics. Histories related to minority status should be taken into account while planning, developing and delivering services to groups that

represent minorities and may well also be marginalized [62,111,112]. Anti-racist and anti-discriminatory policies must be in place [18].

12. Training

In a conference on “Teaching as a competency”, 16 medical and non-medical educators from 10 different U.S. and Canadian organizations developed an initial draft in which they used the physician competencies (from the Accreditation Council for Graduate Medical Education [ACGME]) and the roles (from the Royal College’s Canadian Medical Education Directives for Specialists [CanMEDS]) to define critical skills for medical educators [104]. In a further process, the authors then cross-referenced the competencies with educator roles, drawing from CanMEDS, to recognize role-specific skills. They underlined that the teaching as a competency framework promotes a culture of effective teaching and learning [104]. Beside cultural competence knowledge, skills and attitudes, we should be aware of a teaching competency of the educational leadership. It is also necessary to build local infrastructure to implement cultural competency training. This requires ongoing evaluation, meaning that a part of the implementation should be the development of a process to monitor the training. Accreditations and other methods of local monitoring can support and enhance the status of the ongoing process of the training [62].

13. Recommendations

According to Appleby “It is up to us to examine our attitudes and assumptions about patients from minority groups and to take up training in what is nowadays called cultural competence” [4,p. 401], [54]. It should be considered that even within the same culture there are likely to be variations in attitudes, knowledge, behaviors on the one hand and religious values and linguistic variations on the other [18]. Cultural sensitivity and culturally competent services are key concepts in mental health care services for minority groups. For other marginalized or special groups such as refugees or asylum seekers, specific targeted services may be needed, at least in the initial stages. Trainees’ appreciation of their own background can prepare psychiatrists to respond effectively to the changing configurations of culture, ethnicity, and identity in contemporary health care settings. Furthermore, trainees have specialized cross-cultural psychiatric knowledge and skills, including treatment of refugees and immigrants, socio-cultural variables that influence the assessment and treatment of a wide range of psychiatric conditions, and a comfortable relationship with cultural dynamics that influence both the psychiatrist/patient relationship and collaboration with a wide range of mental health professionals [15,41,60–62,73,81,89]. A correlation between therapists’ satisfaction with training and consultation, treatment acceptability, and the likelihood to use the treatment in the future was reported [49,103]. Way et al. [120] reported a statistically significant increase in communication and interaction, respect for recipients of inpatient care, and increases in cultural competence levels.

Summing up, many recommendations are mentioned in the cited literature. The WPA guidance [8] and the EPA guidance [7] offer recommendations to policy makers, service providers and clinicians. The authors of this guidance agree with these recommendations. We acknowledge that according to the particular interests and issues of policy makers, service providers and psychiatrists, relevant training contents can vary. Focusing on cultural competency and training, we recommend the following:

- policy makers:

- mandatory policies should cover all minority groups, e.g. immigrants, asylum seekers, refugees,
- integrated services should be the preferred norm with culturally specific resources allocated according to patients' needs,
- employment of culturally diverse mental health staff is advised,
- more quantitative and qualitative research on etiological factors, interventions and outcomes must be part of setting up services,
- policy makers must take a lead in ensuring that clear messages on equality and diversity are enshrined in the law with non-discriminatory health policies;
- service providers:
 - the service providers must initiate a culture change within the institutions to make services culturally accessible and sensitive,
 - training all staff in cultural competency, cultural empathy and cultural sensitivity is an absolute must,
 - regular additional training must be part of continuing professional development for all staff,
 - providers should consider the option of employing culture brokers or cultural mediators as these can be of great benefit to both the clinical team and the local communities,
 - regular cross-cultural supervision must be made available directly or using tele-psychiatry,
 - culturally sensitive services such as food and physical spaces should be made available,
 - health education as well as prevention and mental health promotion must be a part of the overall services targeting minority groups,
 - information for immigrants by means of pamphlets in their preferred languages must be easily accessible and available,
 - the institutions should consider having a nominated lead psychiatrist who is responsible for cultural competency training and delivery,
 - qualified interpreters or culture brokers should be available for patients who do not master the language of the host country;
- psychiatrists:
 - training and ongoing education for all mental health professionals in understanding diagnosis, illness behaviors and culturally sensitive interventions must be mandatory when needed,
 - ensuring quality standards for expert court opinions for minority groups in the context of criminal, civil and social law are available and employed in relevant settings,
 - depending upon the needs of local community appropriate knowledge about culture-based medicine, culture-specific, illness-specific and migration-specific aspects must be offered to mental health professionals,
 - information for minority groups in their preferred languages about their rights, psychiatric disorders, treatment options must be made available,
 - cultural psychiatry should be an integral part of all curricula from undergraduate levels to continuing professional development,
 - specific research dealing with the needs of minority groups must be encouraged and appropriately funded,
 - psychiatrists must be aware of their own cultural biases, and have knowledge as to the use of interpreters or culture brokers, culturally different family structures, the effects of discrimination, exclusion, unemployment, intergenerational differences in acculturation, different explanations of illness, symptom presentations and treatment expectations, and idioms of distress,
 - psychiatrists need to possess knowledge of culture and health, culture, illness and psychopathology, and culture in clinical practice.

14. Conclusion

Cultural competency is at the heart of good clinical practice. It is as relevant to majority psychiatrists dealing with minority patients as it is for minority psychiatrists dealing with majority patients. Cultural competence involves professional values, which must include sensitivity, non-discrimination and responsiveness to the psychiatric needs of any patient. There are different models available for cultural competency training and these should be regularly used and also evaluated and properly adjusted if necessary. Cultural competency is “everyone’s business”, and in order to provide services, which are adequate for immigrant patients and their families’ psychiatrists must take the lead in terms of both receiving cultural competence training and putting it into practice. Cultural competence is a multi-faceted skill. It is essential that a thorough evaluation of cultural competence training and cost-benefit analysis of the method be carried out in varying settings. This will enable us to learn how many resources can be saved and how much better patient engagement is. An exploration of idioms of distress, explanatory models and the use of other therapies such as complementary and alternative medicine can then be used to improve and provide efficient and efficacious services for minority groups. Responses from European countries rightly differ but we believe that the core principles as outlined here must be agreed to and employed in further service development.

Disclosure of interest

The authors declare that they have no conflicts of interest concerning this article.

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