Edwards: Stanford Cultural Psychiatry Curriculum Initiative

I. Specific educational aims:

Cultural stigma and differences in cultural forms of expression influence not only the care that individual physicians provide, but also shape health outcomes through institutional practices and healthcare delivery systems.[1] We propose to develop the Stanford Cultural Psychiatry Curriculum Initiative (CPCI), a web-based collection of brief educational resources that psychiatrists can access in real time in clinical settings to help them integrate a sociocultural perspective into their work. Borrowing from the model of the National Neuroscience Curriculum Initiative (NNCI), which creates and disseminates resources in clinical neuroscience education[2], we aim to develop and make available a comprehensive set of interactive online resources and videos for self-study and clinical supervision in cultural psychiatry. In this way, our project is **collaborative**, bringing together practitioners and scholars across disciplines including psychiatry, psychology, public health, history, anthropology, and sociology. Focusing on cultural perspectives, this project will enhance **diversity and inclusion** training across varying levels of psychiatric training. We will **rigorously design** effective educational modules that incorporate qualitative and quantitative feedback from beta-testing. The goal of this initiative is to pilot and utilize these resources at Stanford, but also ultimately to create a **sustainable resource** that is useful to distance learners as well.

II. Project rationale:

Physicians and medical educators have increasingly recognized the importance of cultural influences on mental health and illness in recent decades.[3,4] Both expressions of emotional distress and categories of mental illness differ across cultures;[5] learning to provide care that is informed by each patient's cultural conceptualizations is an essential component of clinical psychiatry training. Yet while physicians and mental health providers understand that culture influences mental health treatment and outcomes, many of these providers feel ill-equipped to address cultural perspectives in real time. A recent Robert Wood Johnson survey cites that while 85% of sampled physicians agreed that "unmet social needs are leading directly to worse health for all Americans," they also lacked confidence "in their capacity to meet their patients' social needs," a barrier which impedes the culturally competent medical care.[1] In conversations with educators across the country, we find that many physicians feel they lack the training and resources to address this critical area of medical education. While model curricula exist for teaching cultural psychiatry in a classroom setting, applying theoretical principles in real time in clinical settings creates a different pedagogical challenge. In this case, learning is self-directed, problem-based, and typically subject to intense time constraints. The objective of the CPCI is to create, pilot and share resources to train physicians across specialties and training experiences to better address sociocultural perspectives in mental illness. Thus, the CPCI curriculum aims to address an important gap in psychiatric education and practice, namely the disconnect between acknowledging the role that culture plays in conceptualizations of mental health and emotional distress and the confidence with which physicians feel equipped to address them in clinical settings. This novel curriculum will be adapted for use across clinical settings, training levels and learning modalities. Trainees will (a) have access to modules that enable them to appreciate different sociocultural perspectives in mental health, (b) be able to demonstrate an appreciation of core concepts in medical sociology, anthropology and psychology, and (c) be more capable of providing culturally competent medical care.

III. Approach:

The goals of this project are to transform existing excellent educational modules into online modalities that can be utilized in real-time in clinical settings. At present, our team has already developed many relevant educational modules that have been presented and well-received in in-person (supervisory and case conference) contexts. These can be roughly divided into conceptual/theoretical modules (e.g., Basics of a DSM-5 Cultural Formulation, Minority and majority identity development, Understanding stereotype threat) and modules relating to a specific cultural community (e.g., Diagnosing and treating religious scrupulosity in Muslim patients, Psychiatric care for older Chinese immigrants, Basic concepts and terminology in LGBTQ health). The adaptation of these in-person modules into an online form

would require refashioning them for a general audience to pick up in any of a variety of clinical settings. Modules will likely comprise brief video clips (less than 5 minutes) as well as interactive activities such as quizzes. Sample clinical cases with stepwise reasoning and discussion may also be posted, along with sociocultural narratives. Part of the project will include identifying experts at Stanford and collaborating with partner institutions to solicit additional curriculum modules.

IV. Timeline and plan for implementation:

October to November 2018: Perform a needs assessment with module testers, supervisors, and experts across disciplines to delineate educational modules most useful in real-time, clinical settings. Administer needs assessment and review data, utilizing said data to inform module design. Seek out partnerships with underrepresented communities.

December 2018 to January 2019: Hire a research assistant. Develop relationships with clinical settings (e.g., inpatient wards and outpatient clinics) to pilot website and modules. Pilot two educational modules based on existing in-person curricula as informed by needs assessment data (total =2).

February 2019: Set up web platform to house modules and create detailed plan for ongoing evaluation of modules.

March 2019 to April 2019: Develop six additional educational modules (total =8). Design and implement trainee and supervisor survey for effectiveness and use of modules. Begin to solicit additional modules from broader range of cultures and clinical contexts.

May 2019: Develop four additional modules (total =12). Administer trainee and supervisor surveys, using results to inform project's next steps.

June 2019: Pilot educational modules in small-group learning formats (i.e., clinical case seminars). Continue to partner with underrepresented communities and clinical contexts to actively solicit high-quality educational modules.

July 2019: Assess next steps in project, prepare for sustainability and crowd sourcing. Seek additional funding if ongoing research assistant would be useful to maintain project. Make website available for a broader audience.

V. Anticipated work product:

We anticipate a publicly available web-based collection of educational resources utilizing multiple learning modalities (e.g., animations, discussions, interactive lessons, case conferences, and problem-based learning) covering topics generated by a group of interdisciplinary scholars and practitioners. The website will be designed with a format that encourages ongoing submissions and continued development.

VI. Evaluation plan:

We will beta test modules and obtain qualitative and quantitative user data to study the efficacy and utility of these modules. Initial stages of data analysis will target accessibility and applicability of the curricular modules, from a trainee and a supervisor perspective, as well as self-assessments of learning and practice improvement. A longer-term assessment goal would be to examine trainees' practice improvement from the perspectives of their patients, although the literature suggests that this is harder to accomplish and the data harder to interpret.

VII. Dissemination of results:

By collaborating across disciplines, we will share the results of this project with members of the medical school and university community. Importantly, we will actively use the modules in real-time clinical settings for medical student and resident education. We will partner with peer institutions to increase the number of modules and contributors to promote further impact and sustainability of the website. We will present our findings in regional and national conferences for psychiatric educators and cultural psychiatrists.

Appendix

References

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