Title: Training and Education to Advance Multicultural Mental Healthcare Delivery (TEAM Mental Healthcare Delivery)

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Focused Question: The proposed project seeks to improve multicultural education for psychiatry residents (n = 15), clinical psychology post-doctoral fellows (n = 2), clinical psychology pre-doctoral interns (n = 10), psychiatric mental health master's specialty program trainees (n = 3), and psychiatric mental health nurse practitioner trainees (n = 2).

Background: RATIONALE: Biases, prejudices, and stereotypes held by healthcare providers result in lower-quality healthcare provided to minority populations (Smedley, Stith, & Nelson, 2003). In line with numerous calls to action to increase competence in providing mental health care that is sensitive and responsive to individuals from marginalized groups (APA, 2003; APA 2017; U.S. Department of Health and Human Services, 2001) and organizational training mandates (APA, 1994), we seek to create opportunities for trainees to receive optimal training in this area while completing their professional training at Duke. We seek to foster interprofessional collaboration by bridging psychiatry, clinical psychology, and psychiatric nursing; and cultivate scaffolding among trainees with differing levels of training in multiculturalism. To this end, the proposed 8-week curriculum has been distilled to its core components and tailored from an existing graduate seminar taught in the clinical psychology Ph.D. program (Nagy, LeMaire, Bhatt-Mackin, Railey, & Miller, in progress) aimed at increasing cultural sensitivity and responsiveness of mental health care providers. The pilot course evidenced high efficacy, acceptability, and feasibility (Nagy, LeMaire, Bhatt-Mackin, Railey, & Miller, in progress). SIGNIFICANCE: Increasing the cultural competence of mental health care professionals may represent a significant route to improving health outcomes and decreasing health disparities for underserved populations (Betancourt & Green, 2010). INNOVATION: There are several noteworthy innovative features of the proposed curriculum, namely that it will (1) center on the constructs that are broadly applicable to multiple identities (versus racial/ethnic group-level knowledge which may perpetuate stereotypes; Lopez, Kopelowicz & Canive, 2002); (2) provide students with specific, concrete, and applicable in-session behavioral indicators of cultural competence; (3) emphasize bidirectional, active, and experiential learning strategies to bolster skills acquisition (Beidas, Koerner, Weingardt, & Kendall, 2011); (4) synergize instruction across programs to bolster scaffolding to enrich the educational experience of trainees; and (5) rely on methodologically rigorous outcome, acceptability and feasibility data to inform sustainable, data-driven future efforts. Importantly, a primary goal of the curriculum is to focus on direct clinical application of material so that students could obtain a tangible and portable skills set (i.e., know how to appropriately, competently, and flexibly respond in the moment when encountering situations in which to apply such skills). COURSE COMPETENCIES: Course competencies include to: (1) gain a level of comfort in cultural dialogue; (2) operationalize multiculturalism and understand the historical context for this movement; (3) develop a nuanced understanding of intersectionality; (4) understand the impact of structural barriers and social position on health disparities in accessing mental health care; (5) be familiar with microaggressions in the clinical encounter; (6) understand how culture influences the presentation of

psychiatric symptoms; (7) increase awareness of personal and professional cultural factors; (8) discuss ways to increase group-level knowledge, examine pros and cons of relying on this knowledge, and ways to engage in hypothesis-testing so as to not perpetuate cultural stereotypes; and (9) incorporate behavioral indicators of cultural competence (i.e., in-meeting skills) into clinical care. COURSE TOPICS: Course topics will include (1) “introduction to curriculum and operationalizing culture and cultural-clinical psychology”; (2) “disparities in mental health care”; (3) “implicit bias, microaggressions, and discrimination in clinical care”; (4) “psychological impacts and unique challenges of immigration on families, acculturative stress, and the Immigrant Paradox”; (5) “cultural idioms of distress and culture bound syndromes”; (6) “culturally-sensitive clinical assessment”; (7) “culturally-responsive case conceptualization”; and (8) “developing cultural competence skills in clinical care and research.” FORMAT AND MATERIALS: A strength of this curriculum is that it is designed to be interactive and experiential, versus relying heavily on didactic instruction. Curriculum materials will be supplemented by optional curriculum readings. These methods are consistent with current guidelines for effective methods to optimally train clinical skills. To that end, meetings will rely largely on experiential exercises (e.g., role plays, case vignettes) and group discussion, and to a lesser degree didactic instruction. Additionally, trainees will be asked to complete several activities outside of training meetings. Application to clinical care

Specific Aims: 1. To adapt and pilot a brief, interdisciplinary multicultural training curriculum for trainees from an existing graduate seminar, which will be delivered either face-to-face (condition 1) or through an online modular training platform (condition 2); 2. To evaluate the efficacy of multicultural training on subjective and objective ratings of cultural competence; 3. To assess comparative efficacy of training delivery modes on subjective and objective ratings of cultural competence; and 4. To assess acceptability and feasibility of the curriculum via qualitative and quantitative measures.

Methods: BRIEF DESCRIPTION OF EDUCATIONAL INTERVENTION : The content for the multicultural training curriculum will be delivered in Fall 2018 (condition 1) and Spring 2019 (condition 2). Trainees will self-select to participate in either condition that will maximize their chances of attending all meetings, given competing clinical demands on their schedules. Assessments will comprise subjective ratings of cultural competence (self-report questionnaires), objective ratings of cultural competence (role play assessments), and qualitative and quantitative ratings of acceptability and feasibility. Subjective and objective ratings of cultural competence will be administered at 4 time points. Namely, as instruction will be delivered sequentially, this allows us to methodologically build in a “waitlist” and extended 6-month follow-up assessment time periods. To this end, condition 1 will be assessed at pre-assessment, post-assessment, 3-month follow-up, and 6-month follow-up. Condition 2 will be assessed at baseline (i.e., while condition 1 receives instruction), pre-assessment, post-assessment, and 3-month follow-up. On pragmatic grounds, condition 2 will not be assessed at 6-month follow-up. Qualitative and quantitative ratings of acceptability and feasibility will be collected during the final course meeting. To assess acceptability, we will rely on quantitative and qualitative ratings of satisfaction. Quantitative items will utilize a Likert-type scale to evaluate satisfaction of the following training components: (1) applicability of content, (2) effectiveness of use of time, (3) helpfulness of content, curriculum organization, (4) instructor’s knowledge, (5) sense of safety, (6) range of topics covered, (7) instructor’s openness and incorporation of feedback, (8) workload, (9) didactic instruction, (10) discussion instruction, (11) experiential instruction, and (12) immersion activity. Qualitative items will comprise open-ended items related to their impressions of “what worked well” and “areas for improvement”. To evaluate feasibility of the multicultural curriculum, we will evaluate percentage of sessions attended and assessments completed. Additionally, we will ask trainees to provide their impressions on facilitators and barriers to engagement in the curriculum. These efforts will guide future refinement of this model, and aid in wide-scale dissemination and implementation. OUTCOMES MEASUREMENT: 1. California Brief Multicultural Competence Scale (i.e., subjective ratings; Roberts, n.d.) 2. Standardized role play assessments (i.e., objective ratings), developed by the research team. 3. Acceptability and feasibility of training questionnaire, developed by the research team. DATA MANAGEMENT AND ANALYSIS: To examine the overall efficacy of the multicultural training curriculum, we will conduct the following statistical analyses: 1. To evaluate the efficacy of multicultural training following completion of instruction, we will compare

change in subjective and objective cultural competence ratings from pre- to post-assessment between conditions, utilizing independent samples t-tests. 2. To evaluate the contribution of passage of time on training outcomes, we will compare change in subjective and objective cultural competence ratings from pre- to post-assessment for condition 1 to baseline assessment to pre-assessment for condition 2, utilizing independent samples t-tests. 3. To evaluate sustainability of training gains across time at 3 months, we will compare change in subjective and objective cultural competence ratings from post-assessment to 3-month follow-up between conditions, utilizing independent samples t-tests. 4. To evaluate sustainability of training gains across time at 6 months, we will compare subjective and objective cultural competence ratings from post-assessment to 6-month follow-up, for condition 1, utilizing a paired sample t-test. 5. To evaluate acceptability and feasibility, we will conduct descriptive analyses (e.g., means, standard deviation) and conduct thematic analysis of qualitative responses.

IRB Status: Plan to submit

Challenges: We are not able to randomly assign to conditions and thus trainees will self-select into either condition. Nonetheless, we will aim to encourage balanced training program participation in each of the conditions to foster interdisciplinary collaboration and scaffolding, as well as to have balanced groups. The PI will be the instructor for the course, and thus will not be blind to condition. However, the use of trained standardized patients and research assistants will allow the research team to increase objectivity of findings. Both conditions will complete 4 assessments. However, to ensure timely completion of the proposed study, the conditions will have differences in assessment points. Namely, condition 1 will be assessed at 6-month follow-up) and condition 2 will be assessed during “waitlist” period (i.e., for 3 months prior the start of their instruction).

Budget: $9960

PI effort		
Consultant	Data collection and analysis will rely heavily on the help of 1 research assistant at $500 per semester ($1,000). To house data, we request a 3-drawer locked filing cabinet ($500). In order to have a standardized patient, we will utilize services from a local talent agency, which charges $720 per day/8 assessment days ($5,760)	7260
Equipment		
Computer	In order to record role play assessments on a secured network, we request to buy a university-approved laptop computer equipped with audio and video recording capabilities ($1,500). Additionally, a laptop will facilitate data collection at various locations in the medical center (e.g., Civitan Psychiatry Building, Pearson Building/School of Medicine). To carry out statistical analyses, we request	1600

	coverage for one year of SPSS software for the PI ($100).	
Supplies	We request $100 to buy office supplies such as pens, computer paper, clipboards, filing hanging folders, highlighters, 3-ring binder clips, and paper clips.	100
Travel	We request $1,000 for conference travel to 1 conference for which the study team will present study findings.	1000

Works Cited: American Psychological Association. (1994). Guidelines and principles for accreditation of programs in professional psychology. Washington, DC: Author. American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. American Psychologist, 58(5), 377-402. American Psychological Association. (2017). Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality. Retrieved from: http://www.apa.org/about/policy/multicultural-guidelines.pdf Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2003). Institute of Medicine, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Unequal treatment: confronting racial and ethnic disparities in healthcare. Beidas, R. S., Koerner, K., Weingardt, K. R., & Kendall, P. C. (2011). Training research: Practical recommendations for maximum impact. Administration and Policy In Mental Health And Mental Health Services Research, 38(4), 223-237. Betancourt, J. R., & Green, A. R. (2010). Commentary: linking cultural competence training to improved health outcomes: perspectives from the field. Academic Medicine, 85(4), 583-585 Lopez, S.R., Kopelowicz. A., & Canive, J.M. (2002). Strategies in developing culturally congruent family interventions for schizophrenia: The case of Hispanics. In H.P. Lefley & E.L. Johnson (Eds.), Family interventions in mental illness: International perspectives (pp. 61-90). Westport, CT: Praeger Nagy, G. A., LeMaire, K., Bhatt-Mackin, S., Railey, K., & Miller, M. (In Progress). Innovative model for strengthening multicultural sensitivity and responsivity in clinical psychology doctoral students: An evaluation of outcomes, feasibility and acceptability of a graduate seminar. Roberts, J. A. (n.d.). California Brief Multicultural Competence Scale. U.S. Department of Health and Human Services. (2001). Mental health: Culture, race, and ethnicity—A Supplement to the mental health report of the Surgeon General. Rockville, MD: Author.