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EMPIRICAL REPORT

Global Mental Health: Five Areas for Value-Driven Training Innovation

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Abstract
Objective In the field of global mental health, there is a need for identifying core values and competencies to guide training programs in professional practice as well as in academia. This paper presents the results of interdisciplinary discussions fostered during an annual meeting of the Society for the Study of Psychiatry and Culture to develop recommendations for value-driven innovation in global mental health training.
Methods Participants ($n = 48$), who registered for a dedicated workshop on global mental health training advertised in conference proceedings, included both established faculty and current students engaged in learning, practice, and research. They proffered recommendations in five areas of training curriculum: values, competencies, training experiences, resources, and evaluation.
Results Priority *values* included humility, ethical awareness of power differentials, collaborative action, and "deep accountability" when working in low-resource settings in low- and middle-income countries and high-income countries. *Competencies* included flexibility and tolerating ambiguity when working across diverse settings, the ability to systematically evaluate personal biases, historical and linguistic proficiency, and evaluation skills across a range of stakeholders. *Training experiences* included didactics, language training, self-awareness, and supervision in immersive activities related to professional or academic work. *Resources* included connections with diverse faculty such as social scientists and mentors in addition to medical practitioners, institutional commitment through protected time and funding, and sustainable collaborations with partners in low resource settings. Finally, *evaluation skills* built upon community-based participatory methods, 360-degree feedback from partners in low-resource settings, and observed structured clinical evaluations (OSCEs) with people of different cultural backgrounds.
Conclusions Global mental health training, as envisioned in this workshop, exemplifies an ethos of working through power differentials across clinical, professional, and social contexts in order to form longstanding collaborations. If incorporated into the ACGME/ABPN Psychiatry Milestone Project, such recommendations will improve training gained through international experiences as well as the everyday training of mental health professionals, global health practitioners, and social scientists.

Keywords Curriculum development · Cross-cultural psychiatry · Global mental health · Medical education · Training innovation

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Building upon the consensus definition of global health [1], global mental health is "an area for study, research and practice that places a priority on improving health and achieving equity in health for all people worldwide," [2, p.xi]. The focus in global mental health (GMH) is thus on achieving equity in

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the distribution of resources for mental health systems, as well as equity in mental health outcomes [2]. The field of GMH is fast-expanding, with increasing attention drawn to the core values that must guide training programs established for professional practice and academic research, both in high- and low-income countries [3–6]. Within GMH, efforts to establish core competencies seek to achieve these dual goals of competence and equity, specifically to benefit partnerships in low-resources settings in both low- and middle-income countries (LMIC) and high-income countries (HIC) [7]. However, core values and required competencies have not been well articulated for GMH training programs in HIC. It is clear, for example, that the field needs to make explicit the value of placing trainees from HIC into LMIC, beyond the benefit of gaining short-term international experience. There are uncertainties and dissonance of expectations that can arise from short-term medical missions [8]. Clearly articulating goals, values, and competencies are essential for GMH training more broadly, within academia and clinical practice. Indeed, reflection on core values is critical to the fields of global health, the social sciences, and medical practice, if we are to hold fast to our stated mandate of care [9, 10].

To address this gap, we convened a formal discussion of such issues to help identify key values, required competencies, training experiences, resources, and evaluation approaches for GMH training for medical/graduate students, trainees in psychiatry residency, fellows and post-doctoral students, social scientists, and collaborators from LMIC. Although GMH as a field seeks to address inequities broadly across settings, our focus was on the competencies relevant for trainees from HIC for working in low-resource settings.

Methods

We took advantage of a specific venue, the 2015 annual meeting of the Society for the Study of Psychiatry and Culture (SSPC), to convene a workshop dedicated to GMH training. The theme of the Society's meeting was "Culture and Global Mental Health." Established in 1979, SSPC (www.psychiatryandculture.org) is a nonprofit, interdisciplinary organization devoted to promoting cultural psychiatry through international efforts to enhance education, clinical practice, policy, and research. The three-day conference (April 23–25, 2015, Providence, Rhode Island) convened 160 participants, of which 48 participated in the workshop dedicated to GMH training. The 2-h workshop was held on April 24th from 1:00–3:15 p.m. as one of three workshops dedicated to focused discussion on specific themes, and entailed no participation fee above that levied for conference registration.

Participants were invited to pre-register for the workshop—those who pre-registered were invited to provide input on what they perceived to be the most important values and competencies for GMH training, through an online free-listing exercise: "Please provide a list of five values that you think should guide the mission of global mental health," and "Please provide a list of five competencies that you think are important for working in the field of global mental health." This pre-conference assignment was adapted from the first step of standard Delphi priority-setting activities [11].

Forty-eight people participated in the workshop. The majority were established academics in the fields of psychiatry (22 faculty, five residents, four fellows), social sciences (six faculty in anthropology and one in sociology), and public health (one faculty), in addition to eight students (in medicine, global health, psychology, and anthropology). There were three practitioners (family physician, public health worker, and human rights lawyer), and eight participants involved as GMH program coordinators (some individuals had joint appointments or were in dual degree training programs). Eleven (23 %) participants were from LMIC, including China, India, Nepal, Guatemala, Mexico, and Venezuela. All participants had first-hand GMH experiences, which included education and training, clinical service, and research throughout all World Health Organization regional clusters, e.g., Central America and the Caribbean, South America, Eastern Europe, Southern and Eastern Asia, and Pacific Islands. Their training work in LMIC ranged from brief clinical programs (e.g., training medical students or primary care workers for 1–2 weeks) to long-term capacity building programs (e.g., multiyear trainings, apprenticeships, and supervision programs). Their LMIC research involved a broad set of methods (epidemiology, services research, biological psychiatry, and ethnography and other social science approaches), with the majority of projects conducted in multidisciplinary teams. Most participants described experiences working in low-resource settings in HIC, as well. All GMH program facilitators had extensive experience in collaborative approaches to training and program implementation.

At the workshop, we employed established techniques for focus group discussion to establish priorities in health education and practice [12]. Participants were invited to complete group work to produce recommendations in five areas, to identify the following items:

1. *Three values* central to GMH training (from the free-listing exercise),
2. *Three competencies* needed to achieve these values (from the free-listing exercise),
3. *Training and experiences* needed to achieve such competencies,
4. *Resources* needed to provide such training opportunities, and
5. *Evaluation techniques* to demonstrate competence in GMH practice and research.

These recommendations were developed with the aim of providing insights for innovation on important aspects of GMH activity in order to benefit five main stakeholder groups namely, (1) medical/graduate students, (2) trainees in psychiatry residency, (3) fellows and post-doctoral students, (4) social scientists, and (5) collaborators in low-resource settings.

Workshop participants self-selected into discussion groups for these five categories. They could choose to join any of the five stakeholder groups, regardless of their own stages of training. Formation of heterogeneous groups was encouraged: we used mixed groups to foster discussions about successful or challenging aspects of current inter-disciplinary programs and training. Groups with participants at different career stages could reflect together on what aspects of training were most helpful given current activities.

Each round table was provided with the list of values and competencies generated by the online free-listing exercise. Participants were then instructed to identify the three most important core values and competencies from the existing list, or to generate their own alternatives. They were also asked, in three consecutive blocks of time, to identify their most important recommendations for training experiences, resource needs, and evaluation techniques.

After discussion, each round table took the stage to share their main recommendations to workshop participants at large, crystalizing them into short concluding statements. The five group presentations, and the discussion that followed, were audio recorded for transcription. Participants were informed that the purpose of this exercise was to disseminate their recommendations in academic venues.

Results

The online free-listing exercise yielded a list of 31 core values and 28 required competencies for GMH training. These lists were provided to the five groups, in order to seed discussions and achieve consensus on identifying the most important items. We summarize the recommendations of participants below. The supplementary material available online includes a breakdown of items by domain for each group.

Values

In the online free-listing exercise, values related to equality and equity (e.g., social inclusion, access to care, gender equality) constituted 19 % of responses. Sustainable partnerships and collaboration, including support of both human capital and infrastructure, constituted 16 % of responses. Cultural and linguistic competence, including knowledge of idioms of distress, constituted 13 % of responses. Other responses included humility (10 %), justice and human rights (10 %), differentiating distress versus disorder (6 %), do no harm (6 %), and respect (6 %).

Building upon these lists, workshop groups prioritized humility, respect, and ethics in the context of collaborations. The quotes provided below and in subsequent sections represent consensus statements from workshop groups.

- "Our salient values are *humility* and *respect for others*, *partnerships* that value working with a diverse group, and… *being compassionate*."
- "For values, we discussed having long-term collaborative ethical and sustainable partnerships, being *open-minded* and *respectful* of other cultures and patient experiences and suffering, and *humility*."
- "… mutually-beneficial *collaboration*, *humility*, *open-mindedness*, *respect*, partnership, infrastructure, capacity building, and knowledge for sustained training [are important values]."
- "We developed an acronym for the core values – PAR – namely, *Partnership, Accountability, and Reflexivity*. When we say accountability, that is not merely tracking the money flowing into a program, but rather an accountability to people, what is known as *deep accountability* to a people-centered agenda. By reflexivity, we mean that you are constantly holding a critical eye to the performance of what you are doing."
- "Our first value is to form *collaborative, mutually beneficial relationships* with partners abroad, our second was *respect* and understanding of local mental health treatment approaches, and lastly conducting long term *ethical* and sustainable work."

Competencies

The largest category of competency free-list responses (21 %) referred to cross-cultural communication including knowledge of idioms of distress and other culturally appropriate ways to discuss mental health in a non-stigmatizing manner. Other competency categories included the ability to collaborate in interdisciplinary teams (14 %); conducting self-evaluations of clinical, research, and community engagement practices (11 %); aptitude in family and couples therapy (11 %); conducting cultural formulation interviews and eliciting explanatory models (11 %); knowledge of WHO essential medications and government free drug lists in respective countries (4 %); evidence-based teaching and training strategies (4 %); culturally adapting treatment manuals (4 %); evidence-based approaches to advocacy (4 %); and other competencies (20 %).

Workshop groups emphasized a range of competencies from listening skills to knowledge of political context to critical thinking skills:

- "The primary competency that we would like to gain is *a non-judgmental approach*, which includes tolerance."
- "Competencies within this ideal partnership include *understanding systems* and how they operate, ways to foster collaboration, and how to evaluate that relationship. Within an open-minded, non-judgmental stance are competencies for *good listening skills, flexibility, tolerating ambiguity and differences, and being open to new experiences*. Competencies under humility include *self-awareness* and *recognition of power differentials*, resource differences, cultural biases, and systems differences."
- "[The main competencies were] flexibility, [sensitivity to] bias, humility and *being able to treat mental disorders in a manner appropriate for the cultural context*. A second group of competencies is *knowing the cultural and political context* of the situation where you are providing care."
- "Our competencies are *interdisciplinarity, critical thinking skills* or *deep knowledge of context*, and *ethical engagement*. In other words, we want to draw attention to our accountability to people rather than to the program."
- "Competencies that we chose were, first, *awareness of biased assumptions*, and, second, knowledge, skills, and attitudes specifically regarding *systems, operational management*, and *team based approaches*. When we expanded on the competencies, we wanted to think about modeling self- evaluations, and the awareness that we all have biases and allow our own biases to be shared, and [demonstrate] how sharing can normalize these biases. We wanted this to be in group settings in LMIC settings."

Training

Training included (a) class didactics with a focus on ethics, history, and critical social theory; (b) experiences fostering self-reflection and awareness; (c) immersive field experiences; and (b) health systems practice and theory:

- "Training would include *classes in ethical considerations* of science grounded in history, self-awareness and reflection."
- "Training should be incorporated into basic psychiatry training and offer additional in depth opportunities for those with specific interest. Prior to international experiences, training should include case presentations with analysis accompanied by didactics and locally relevant preparation and experiences. Training should be longitudinal and include experiential training as well as mentorship. Many of these elements are in psychiatry training; the added value includes how the training experiences are framed and expanding existing components to address their global applicability. We recommend optimizing components of existing training for all residents versus relegating these elements to only a dedicated elective for a subset of trainees. For example, in general residency, one should consider non-familiar populations that residents are not currently encountering and practicing the competencies of a non-judgmental stance, humility, self-awareness, and sensitivity to power differentials. Methods to accomplish this include *role-plays, 360-degree evaluations, some coursework and didactics on the history of both GMH and the regions of the populations referenced*."
- "For training, a key experience is *conducting a self-cultural formulation* and other systematic approaches to understanding oneself. Part of this process includes job training and doing preparatory work before you go for an international experience."
- "For gaining actual training experience, we recommend *immersive field experiences, critical social theory, and mixed research methods*. Note that immersive practice means to 'be with the people', and note that critical skills and mixed methods allow you to better communicate across disciplines, which is necessary for GMH training because we all need to engage with other perspective."
- "Regarding [training] skills: we wanted to get a broader sense of what are social determinants of what problems are occurring and eliciting what is important and incorporating that material into our content. Regarding who are the voices [that matter], [if] we [mental health specialists] are the only voices represented, [then it] is not effective. So, [we should] have global voices, including nurses, parents, policy makers, traditional healers, and other LMIC stakeholders who are going to be involved [in any implementation, practice, and research]. The last competency group was skills and attitudes for team based work. [This includes] what services are already embedded and finding out about the infrastructure, we want to bring in experts who do have knowledge about *operational management and systems* both in our economies and the ones we are trying to work with. We want for things to be feasible and sustainable because we don't want to be a burden to the people we are working with."

Resources

Resource needs incorporated funding, curriculum development, mentorship, and long-standing partnerships with local collaborators wherever training, clinical, or research activities are conducted:

- "In terms of resources, we need educational leadership buy-in for *curriculum development*, *physical space and materials* [for teaching] and *flexibility in tailoring programs* in order to accomplish all of this. We need *faculty training* and buy-in and expansion from the traditional faculty to include *non-medical faculty, service users, and other stakeholders*. For end-user engagement involvement, it may be good to use technology… We need people with *language expertise* and *partnerships in terms of local faculty, field site staff, and other partners*. We will [also need institutional support to develop and implement] an evaluation system in terms… We have envisioned an *introductory course* [for medical and graduate students] plus a *longitudinal didactic component*. That said, we need to ensure [that training] is not only didactically but really interactive and participatory. Incorporation of technology will facilitate training evaluation and trainee buy-in… Student buy-in comes in two types: all students should be invested in gaining skills in being nonjudgmental, which would be a universal competency, and in particular, there would be students who are interested specifically in GMH, who would need advanced training."

- "In terms of resources, time and money, including salary support, are vital. You also need commitment and on the parts of trainees for continuity of their partnerships and as well on the part of faculty who are going to be providing the courses, mentorship, and training programs. Within the institution, you need *inter-institutional partnerships* and *collaboration with social sciences* and other colleagues including collaborating with non-medical partners."

- "Crucial to training experiences would be *role models and mentors*. In terms of resources, we would need time, [availability of personal] therapy, a flexible curriculum with time to explore and have tailored experiences, as well as having a *mentor* to help with the timeline and local partnerships."

- "Our first-priority resource is diverse *mentorship*. Second, we need *platforms of exchange*, ones that facilitate a brokering of knowledge. And as a third important resource, we need innovative *funding*, namely funding that allows you to pursue good ideas."

- "Regarding resources: we need *train the trainer models* within the country context that we are working… We need *relationships with institutions* already locally present, and we need to have their support and positive relationships with them no matter what. We need the framework to be sustainable and dynamic… to periodically reevaluate and do assessments to see if it is working and make adjustments… [We need a] *collaborative process of making goals* with whomever we are working."

Evaluation

Evaluation priorities highlighted self-evaluation including assessing impact on local communities and partners. In addition to clinical skills, assessment of language and other context factors were prioritized. Feedback from partners and beneficiaries was considered indispensable.

- "Evaluations should measure *attitude and skills*, such as using observations to look at one's attitudes and using a 360 [degree feedback; 360 degree feedback refers to a form of multi-rater feedback comprising supervisors, direct reports, peers, and self evaluation]. *Knowledge* pre- and post-tests would be another way to evaluate training gains… Another way to evaluate is through *language testing* because a GMH training program should include language skills. *Patient satisfaction* [tools] would be one way to see if someone is being compassionate… There should also be participation indicators to see to what extent people are involved in the community. Self-reflection should be included as a personalized component. There should also be project component with specific logs, and, if applicable, a thesis. [We should also document] presentations and publications."

- "For evaluations, there is the *individual level, the program level, and the collaborations abroad*. We prioritize how to evaluate yourself as a way of maximizing your effectiveness and contribution to GMH, including assessing longevity and functioning as basic factors. Prior to going abroad, one can practice with an evaluation simulation considering the competencies discussed above as influenced by the core values. Evaluation of both the trainees in the program and the work they are doing abroad is critical. To evaluate your impact, one can *track the scholarly projects* being done."

- "In terms of evaluations, it is key to obtain *evaluations from those who will be potentially benefitting* [from the services]. Surveys could be used to evaluate the quality of [collaborative and clinical] relationships and how time was spent in electives."

- "Finally, in terms of evaluation, we want three things. One is iterative process reports that focus on the 'how' and 'what' you are doing, namely, *reports that evaluate the GMH training process and not just training outcomes*: we would like to know *how* you are doing not just *what* you are doing in training programs. Second, we want a focus on *systematic community feedback on training programs* because you need people's input and buy-in all along the way. And finally, we need a *critical knowledge dissemination* to be able to learn from the past and foster innovation and good practice."

- "For evaluation metrics, we should incorporate existing metrics; some are web-based. We want to measure who we are reaching, and have things changed as a result of our involvement. How effective is our work and what are the outcomes? We want to do *self-evaluation* and see how effective we are in providing services that we think we are providing, and how effective are we in comparison to who is already doing the work. We also wanted to integrate the consequences of our participation, we do not want burden others with consequences on our participation. This *integrates social determinants* in the context. We also want to incorporate what are their targets and objectives and what social inequalities affect their impact. This can be done through a case presentation to find out who are the people involved and what are the skills of the people involved in the programming."

Discussion

Participants were tasked with developing recommendations for GMH values and competencies, as well as defining the training experiences, resources, and evaluation techniques that can help achieve these goals. Our findings are a useful starting point for improving GMH training, especially where scholars and professionals from HIC work in collaborations in LMIC institutions and in low-resource settings in HIC. Figure 1 provides an overview of key elements in a value-driven GMH training program, including specific resources from existing short courses.

The group consensus about *values* central to GMH training focused on humility, attention to ethics, and the development of collaborative partnerships. "Deep accountability" to patients and their families was emphasized in order to focus attention on a people-centered agenda [9, 15], as well as accountability to clinical and research collaborators in LMIC and other low-resource settings in response to the historical global health efforts where priorities were defined by individuals and institutions in HIC imposing a colonialist vision of human rights without local input or understanding the local context [13]. Recent examples in global health and GMH demonstrate a commitment to "deep accountability" and collaborative partnerships [6, 9, 14, 15]. Multiple *competencies* were highlighted to achieve these values, among them, flexibility; ability to tolerate ambiguity and to evaluate one's personal biases; understand critical theory in social science; historical and linguistic knowledge related to clinical populations and community settings; and skills required to evaluate impact across a range of stakeholders, from patients to clinical collaborators to policy makers. Many of these elements have been highlighted by the recent call to shift away from cultural competency to structural competency in training medical professionals [16]. The group proposed various *training experiences* to achieve these competencies, including didactics in global health, medical anthropology, critical theory, philosophy, and ethics; language training; training in self-awareness and structured reflection; supervised local experiences across cultural groups; and supervised immersive field experiences in settings with low resources. More guidelines should be produced for collaborative engagement, such as recent recommendations for collaborative academic writing for LMIC-HIC research partnerships [17].

Consensus about *resources* was unanimous for broad base multidisciplinary faculty/mentorship including social scientists and other non-medical mentors [18], institutional commitment through protected time and funding for GMH faculty [19], and sustainable collaborative partnerships between practitioners and researchers working in high- and low-resource settings. The resource challenges are global, although exponentially worse in LMIC. Few HIC institutions offer the described resources to trainees in GMH. Those in LMIC and other low-resource settings are often burdened by a range of clinical, research, and administrative duties due to the lack of mental health specialists in most these settings, and many have little or no access to training and supervision. Free access to online courses and investment in information technology was proposed as a first step to enhance learning opportunities for LMIC collaborators.

The group emphasized the need to *evaluate* trainings to demonstrate competence in GMH, and several possible modalities were discussed. Evaluations are required for all career stages (e.g., trainee/student, faculty/mentor), as well as for the multiple stakeholders involved in the research (e.g., community, patient, relative, provider, administrator, policy maker, researcher, etc.). Ultimately, by developing a range of competency evaluation approaches, GMH training programs will be better positioned to judge preparation and the degree of supervision needed for GMH experiences.

From introspection to deep accountability, the need to address power differentials through active collaborative partnerships was widely discussed [14]. Critical medical anthropology explores power differentials within socioeconomic

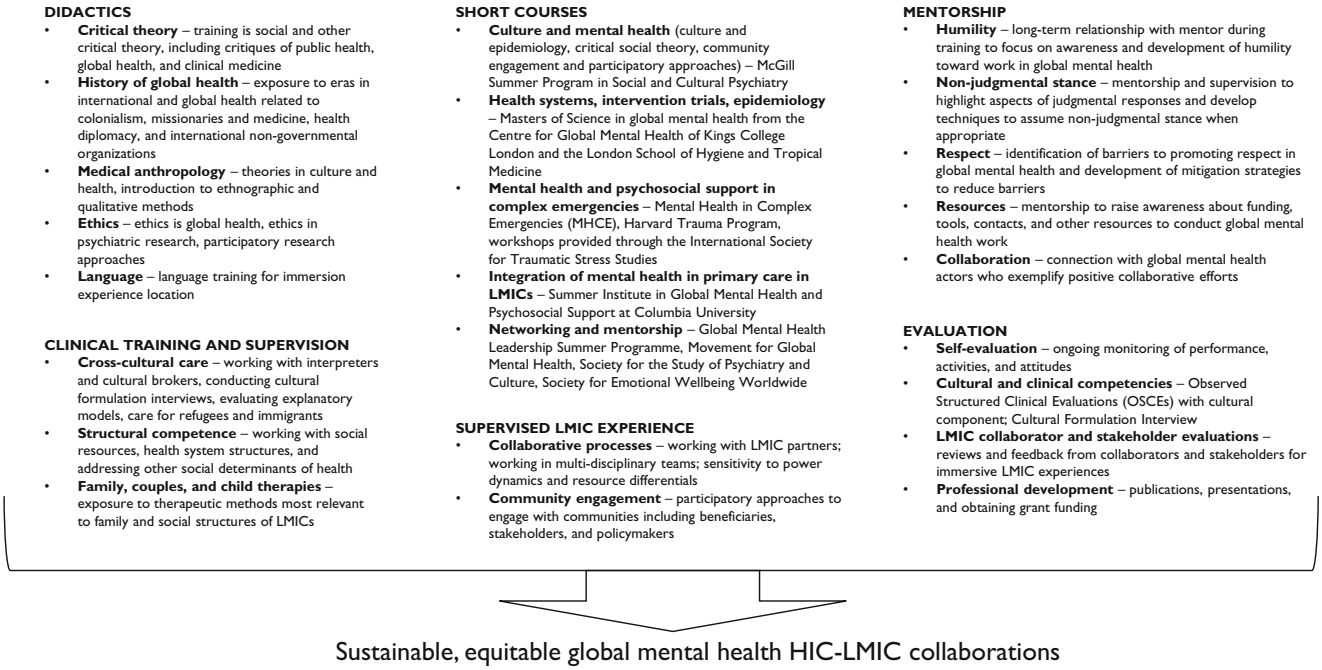

Fig. 1 Components for value-driven global mental health training

systems, medical systems, and patient-provider interactions [20]. Collaborative models such as Community Based Participatory Research (CBPR) [14] can provide both a training and a research framework to provide feedback to research teams; facilitate communication between researchers and communities; and challenge assumptions about needs, barriers, facilitators, conflicts and potential approaches. Further, adaptability, flexibility and managing uncertainties are skills attained through frameworks like CBPR.

GMH training can build upon the use of observed structured clinical evaluations (OSCE) in clinical training. A cultural OSCE has been developed to evaluate working with diverse populations [21]. A GMH therapist common factors tool has also been developed for evaluation of both trainees and GMH practitioners, and it can be incorporated into evaluation of non-specialist health workers in diverse cultural settings [22]. New materials exist for training in the cultural formulation interview [23].

Psychiatric residency training Accreditation Council for Graduate Medical Education (ACGME) competencies [5] or the goals of The Psychiatry Milestone Project by the ACGME and The American Board of Psychiatry and Neurology (APBN) [24] closely align with the GMH competencies defined by the workgroup. Psychiatry Milestone Project categories relevant to GMH include Professionalism (PROF), Psychiatric Care (PC), Interpersonal and Communication Skills (ICS), Medical Knowledge (MK), and Systems Based Practice (SBP). Competencies contributing to humility, respect, and compassion when working across cultural groups are reflected in Milestone PROF1, "Compassion, integrity, respect for others, sensitivity to diverse patient populations, adherence to ethical principles." Milestone PC4, "Psychotherapy," is a good example of how this self-awareness is integrated into treatment planning, e.g., "Personalizes treatment based on self-awareness." The concept of *deep accountability* fits with the Milestone PROF2, "Accountability to self, patients, colleagues, and the profession." Promoting long-term GMH collaboration is also an extension of Milestone ICS1, "Relationship development and conflict management with patients, families, colleagues, and members of the health care team." Other GMH competencies are reflected in MK1, "Development across the lifespan" through an item on "cultural and economic influences on personality development"; and in MK2, "Psychopathology," which emphasizes competency "in diverse patient populations." And finally, Milestones SBP3, "Community-based care" which includes designing systems and using community groups and advocacy groups, and Milestone SBP4, "Consultation to non-psychiatric medical providers and non-medical systems", are both central to effective GMH work.

Regarding limitations, this process represents views of a self-selected group of attendees of an annual conference of a single academic professional society. Their views may not represent views on the practice of psychiatry or the conduct of GMH research in the rest of the field. We used a process of heterogeneous groupings to develop priorities for different stages of training in order to foster collaborative approaches from various perspectives and career paths. If we had used homogeneous groups, e.g., limiting the post-doctoral group

only to current fellows, doing so would likely have produced a different set of recommendations. Collaborative processes of developing training recommendations with other professional societies [7, 25] would be beneficial to identify priorities not captured through the limited procedures we conducted at a single academic professional society conference with time limitations. More importantly, the workshop participants emphasized the need for involvement of LMIC clinicians, research, and institutional partners to be central in identifying values and competencies within training programs. Eleven clinicians and social scientists from LMIC (23 % of participants) engaged in the workshop, but most were currently based in HIC institutions. Therefore, future training priority setting activities are needed with LMIC collaborators based in LMIC institutions.

In conclusion, GMH training, as envisioned by participants in this workshop, needs to be grounded in an ethos of recognizing and working with power differentials across clinical, professional, and cultural context to form longstanding collaborations. The ability to identify, engage with, and shift power dynamics is an aspect of good social and psychotherapeutic skills: GMH presents an opportunity to apply these important skills to a broad systems level, striving for both cultural and structural competence in meeting the needs of people and their families across diverse communities. This will help achieve the objectives of GMH to decrease disparities in access to quality mental health care.

Implications for Educators

- Innovations in global mental health training rest upon promoting key values, such as humility, collaboration, and sensitivity to power differentials, for collaborative work partnerships.
- Global mental health key competencies include tolerating uncertainty, systematically evaluating personal biases, and engaging with diverse stakeholders.
- Global mental health training must include didactics on history, ethics, and culture; language training; and supervision in low-resource settings.
- Global mental health training programs require diverse faculty including social scientists, sustainable international partnerships, and protected time and funding for trainees and faculty.
- Evaluation of global mental health trainees must include cross-cultural OSCEs, feedback from international partners, and community-based outputs and outcomes.

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ONLINE SUPPLEMENT: Five areas for value-driven global mental health training based on stage and type of training

	Graduate education (medical, public health, and global health students)	**Psychiatry residency**	**Psychiatry fellowship and post-doctoral training**	**Social science training**	**Training for LMIC collaborators**
Values	• Humility and respect • Partnerships and inclusion • Practicing compassion and do no harm	• Long-term collaborative ethical and sustainable partnerships • Open-minded; respectful of culture, patients' experiences, and patients' suffering • Humility	• Mutually beneficial collaboration entailing respect, partnerships, humility, and open mindedness • Commitment to sustaining infrastructure in LMIC • Commitment to capacity building	• Working in partnerships • Accountability • Reflexivity	• Forming collaborative, mutually beneficial relationships with partners abroad • Respect and understanding of local mental health treatment approaches • Conducting long-term, ethical, and sustainable work
Competencies	• Engaging with others in a non-judgmental approach, demonstrating respect, tolerance, and cultural competence • Demonstrating knowledge of ethical considerations and historical context of LMIC when developing collaborations and conducting activities • Ability to perform evaluation of impact for GMH projects and experiences upon relationships, training, and patient outcomes	• Operating within health systems in a manner that demonstrates ethical principles and sensitivity to power differentials • Demonstration of common factors, e.g., listening skills, non-judgmental approaches, flexibility, tolerating uncertainty; • Ability to conduct socio-cultural formulations	• Demonstrating flexibility, humility, and awareness of personal biases • Ability to distinguish distress vs. disorder in cross-cultural context • Engaging with others in a manner that demonstrates sensitivity to cultural context and politics • Demonstration of writing skills with ability to communicate to diverse audiences	• Ability to work in Interdisciplinary teams • Design projects and conducting GMH activities in a manner that demonstrates critical thinking skills and deep knowledge of context • Engaging with others in an ethical manner	• Ability to demonstrate awareness of biases and assumptions through self-evaluation • Ability to incorporate social determinants of health into activities • Ability to engage with a range of stakeholders and partners including families, nurses, community health workers, policy makers • Ability to work in health systems to maximize sustainability, feasibility, and minimize burden
Training experiences	• Training in self-awareness and reflection skills • Coursework in language, cultural context, history, and philosophy	• Longitudinal didactics, case based learning, and mentored reading and preparation prior to LMIC experiences • Expansion of current training to consider non-familiar populations • Specialized training in LMIC settings • Community-based experiences	• Training enhance understanding of oneself • Training in performing self-cultural formulations • Working with refugees and immigrants prior to LMIC experience • Mentorship from GMH practitioners • Encouragement to develop personalized training experiences	• Immersive fieldwork and practice in LMIC settings • Didactics and facilitated discussion in critical social theory • Training in mixed research methods	• Working in health systems in LMIC • Working with a range of stakeholders • Working on projects the address social determinants of health

	Graduate education (medical, public health, and global health students)	Psychiatry residency	Psychiatry fellowship and post-doctoral training	Social science training	Training for LMIC collaborators
Resources	• Buy-in from education leadership as demonstrated by provision of protected time for GMH activities • Availability of pilot grants • Access to faculty with GMH experiences and faculty other than clinicians • Support for engagement with end-users and beneficiaries • Technological infrastructure to collect feedback and present it in a manner to facilitate dynamic learning environments • Availability of language instructors in a range of languages for LMIC settings • Availability of partnerships for local community based participatory processes and global field experiences • Ability to conduct longitudinal courses over multiple years for preparation and debriefing • Simulated patient evaluations using cultural frameworks	• Dedicated time and salary for residents to participate in GMH experiences • Critical mass (over multiple years) of committed trainees who can provide continuity in training program and GMH experiences • Faculty with protected time and salary support for GMH • Funding for GMH clinical and research work • Inter-institutional partnerships • Mentored engagement, including with non-medical professors, such as collaborations with social science colleagues	• Protected time for GMH training and experiences • Availability of psychological therapy for GMH trainees to prevent distress with functional impairment and to promote self-awareness • Flexibility in training and clinical curriculum and scheduling • GMH mentors • Local partnerships	• Diverse mentorship • Platforms for knowledge brokering • Innovative funding	• Train the trainer models within country context • Relationships with institutions with supportive infrastructure • Sustainable dynamic frameworks for learning health care systems that include periodic re-evaluation and re-design • Human and technological resources for ongoing collaborative goal and priority setting
Evaluation	• Scales to assess attitudes and biases • Observational tools including Observed Structured Clinical Evaluations (OSCEs) • 360-degree feedback evaluations • Knowledge tests of cultural context, history, and ethics • Clinical adherence and fidelity ratings for use with cross-cultural patient populations • Participation indicators specific to project requirements • Self-reflection assessment through diary records and engagement logs • Academic productivity including thesis and publication requirements	• Patient and colleague feedback in LMIC settings (e.g., 360 degree feedback) • Observed and evaluated simulations (e.g., OSCE and other simulated role plays) • Self-assessment including evaluation of changes in thinking and approach	• Measure of ability to sustain engagement and activity • Surveys of knowledge, attitudes, and reported practices • Academic productivity measured through paper publications • Quantification of time available and time engaged in GMH electives	• Iterative process reports • Systematic community feedback • Assessment of knowledge dissemination to beneficiaries, stakeholders, funders, etc.	• Output of number of participants in activities, e.g., number of participants in train-the-trainer programs • Output of number of beneficiaries reached • Process indicators of number of referrals • Evaluation of accuracy of diagnoses across context • Tools to capture unintended consequences of participation • Use of case studies to evaluate specific projects, outputs, and outcomes • Self evaluations

Abbreviations: Global mental health (GMH); Low- and middle-income countries (LMIC), Observed structured clinical evaluation (OSCE)