Final Report: Evaluation of the WDHB CALD Cross-Cultural Training Course

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1.0 INTRODUCTION

This is the final report for the evaluation of the WDHB CALD Cross-Cultural Training Course Module 1. It provides the outcomes of the evaluation, which employed a mixed methods research design.

1.1 Background

Super diversity is the term used to describe any city that has a significant proportion of its population from culturally and linguistically diverse (CALD) backgrounds. Auckland is one of the most super diverse regions in the OECD and it has become so in a relatively short period of time, the two decades from 1990 to 2010. Approximately 40% of the resident population in the Auckland region have identified as being born overseas. This number is even higher for areas such as Albany where 50% of the residents are overseas born. This proportion is significantly ahead of Canadian cities and the nearest Australian city, Sydney, where 32% of the residents are overseas born.

CALD cultural competence training for the health and disability workforce is important because of the increasing number of CALD patients in the Auckland region. There is a demand for access to CALD cultural competency training from the health workforce because of their growing concerns about miscommunication between practitioners and their CALD clients; the risks of misdiagnosis; and poor compliance with treatment and management plans. The need to meet the cultural competence requirement of Health Practitioners Competence Assurance Act 2003 has been a major incentive for practitioners to complete the CALD training.

To enable the Auckland region primary and secondary care workforce to have access to CALD cultural competency training and to meet the learning needs of busy health practitioners, the Northern DHB Support Agency (NDSA) contracted Waitemata DHB (WDHB) Asian Health Support Services (AHSS) from March 2009 to develop firstly:

(1) A suite of CALD cultural competency face to face short courses that:

1. achieve the quality and standards required by the Registration Board's cultural competency standards requirements;

2. are well designed, interactive, engaging, fun, dynamic, educational, self-reflective and are evaluated at the end of the learning process;
3. have good quality video (and audio) scenarios to enhance learning and enable learners to visualize how to work with CALD patients;
4. are able to achieve the quality and standards necessary to provide professional development points for the health practitioners undertaking the CALD training courses

and secondly;

(2) a suite of CALD cultural competency online courses that offer the learners mixed learning options. The online courses must achieve the same requirements outlined in (1) above. Additionally, the online course must be easy to navigate, self-paced and provide an auto-generated certificate.

The following list is the suite of CALD cultural competency courses which were available at the time of the evaluation[1]:

- CALD 1: Culture and Cultural Competency
- CALD 2: Working with migrant (Asian) patients
- CALD 3: Working with refugee patients
- CALD 4: Working with interpreters

The courses are designed to ensure contextual and layered learning experiences that progressively enable learners to increase and enhance their:

1. ***awareness*** of their own culture and attitude towards cultures different from their own
2. ***cultural sensitivity*** when working with CALD patients
3. ***knowledge*** of cultural differences such as values, health beliefs, religious beliefs, health seeking behaviours, customs, gestures, as well as awareness of the migrant

[1] The full suite of CALD courses available in 2012 includes:
- CALD 1 Culture and Cultural Competency (e-learning and face to face)
- CALD 2 Working with migrant (Asian) patients (e-learning and face to face)
- CALD 3 Working with refugee patients (e-learning and face to face)
- CALD 4 Working with Interpreters (available e-learning and face to face)
- CALD 5 Working with Asian mental health clients (face to face only)
- CALD 6 Working with Refugee mental health clients (face to face only)
- CALD 7 Working with Religious Diversity (e-learning and face to face)
- CALD 8 Working with CALD families – Disability Awareness (e-learning and face to face)
- CALD 9 Working in mental health context with CALD clients (e-learning and face to face - under development)

journey and the refugee experience etc which impacts on the patient-health practitioner interaction/ communication/ engagement/ service uptake/ service responsiveness etc.

4. ***skills*** to work cross-culturally. The ability to work with and to communicate effectively with CALD patients.

It is important to acknowledge that Maori is the indigenous culture of New Zealand and Auckland has the biggest population of Pacific people in the world and that there are cultural courses already available for working specifically with Maori and Pacific populations.

AHSS contracted the Goodfellow Unit, a recognized Royal New Zealand College of General Practitioners (RNZCGP) provider, to project manage and provide the e-learning design solution to turn the content of the existing classroom modules into accredited e-learning courses. In line with the above, AHSS has commissioned UniServices Ltd. to evaluate the face to face and online CALD Culture and Cultural Competency training course, which is the pre-requisite to CALD 2, 3 and 4 courses.

1.2 Purpose of the evaluation and research questions

The purpose of the study was to evaluate Module 1 of the CALD cross-cultural training programme. To this end, an evaluation was designed to address the following questions:

1. What impact has the completion of Module 1 of the CALD programme had on participants' cultural competence? More specifically, what has been the impact on the following aspects reflective of cultural competence?
    - Awareness
    - Sensitivity
    - Behaviour

2. What are participants' views on the content and quality of Module 1 of the CALD programme? Do these differ as a function of mode of delivery? (i.e. face to face versus on-line) Aspects explored pertaining to programme content and quality were:
    - Delivery of programme
    - Quality of materials
    - What aspects of the course were most helpful?

3. How has the course impacted on participants' practice?

In order to address the evaluation questions, a mixed methods approach was employed incorporating both quantitative and qualitative methods.

2.0 METHOD

2.1 Recruitment and Sample

All those who enrolled in Module 1 of the CALD programme between 1st March 2011 and 30th September 2011 were invited to participate in the evaluation study. The research team and the team at Asian Health Support Services continued, until the closure date, to ensure maximisation of participant numbers. This included the research team contacting all potential participants to ensure they had received the email invitation to participate. All those recruited were invited to complete a questionnaire before (Time 1) and after completion of Module 1 (Time 2). Table 1 shows the numbers of invitees completing the questionnaires.

Table 1: Numbers of those invited to participate who completed the pre questionnaire (Time 1), the Module and the follow up questionnaire (Time 2).

CALD Cross Cultural Training Course		
Completed pre-questionnaire (T1)	Completed Module 1	Completed post-questionnaire (T2)
249	165	108

On completion of data entry and cleaning there were 249 participants who had completed the pre questionnaire (Time 1). Subsequently, 165 (66%) of these people went on to complete Module 1, and of these, 108 (65%) completed the post questionnaire (Time 2). Seventy eight percent (n=194) of those completing the pre questionnaire were enrolled in the online version of the module.

2.2 Demographic characteristics

The demographic characteristics of those participants completing the questionnaire at Time 1 only (n =249), and those completing the questionnaire at both Time 1 and Time 2 (n=108) are presented in Table 2.

Table 2: Summarising the demographic characteristics of the sample completing the questionnaire at Time 1 and both Time 1 and Time 2.

	Completed Time 1		**Completed Time 1 + 2**	
	N	%	N	%
Gender				
Male	27	10.8	15	13.9
Female	222	89.2	93	86.1
TOTAL	**249**	**100.0**	**108**	**100.0**
Ethnicity				
NZ European	141	57.2	64	59.8
European (other)	53	21.5	24	22.4
Asian	22	8.9	13	12.1
Maori	8	3.2	1	0.93
South African	8	3.2	0	0
Indian	7	2.8	3	2.8
Pacific Island	6	2.4	1	0.93
Middle Eastern	2	.8	1	0.93
TOTAL	**247**	**100.0**	**107**	**100.0**
Occupation				
Nurse	112	45.5	54	50.9
Admin [Health]	36	14.6	13	12.3
Psych/Social Worker	24	9.9	7	6.6

Doctor	12	4.9	4	3.8
Pharmacist	7	2.8	4	3.8
Allied Health	27	11.0	9	8.5
Dietician	7	2.8	4	3.8
Student	5	2.0	2	1.9
Other	16	6.5	9	8.5
TOTAL	**246**	**100.0**	**106**	**100.0**

The age of participants ranged from 21 years to 74 years with a mean of 45 years.

As can be seen from the information in Table 2, the majority of participants were female nurses who identified as NZ or European - other. Further, the demographic breakdown of the sample did not appear to differ greatly from Time 1 to Time 2; that is, the composition of both samples was very similar.

It is interesting to note that of the 124 nurses and doctors who completed the pre questionnaire, 58 (47%) went on to complete Module 1 and the post questionnaire, a similar completion rate (44%) to the 'Other' occupational group.

Previous Cultural Competency Training

Just over half (*n*=135) of the participants at Time 1 had undertaken prior cultural competency training.

As can be seen in Table 3, of those participants who reported having had previous cultural training, approximately 1/3rd reported that this was an 'in house' programme and approximately 20% reported that the training was associated with a university course.

Table 3: Types of previous cultural competency training undertaken and the mean time and standard deviation since training had been completed.

Type of training	N	%	Years since completion	
			M	SD
In house	92	36.9	3.8	4.8
Treaty of Waitangi/Maori	36	14.6	3.8	4.2
Part of University course	47	18.9	10.2	8.7
Pasifika course	21	8.4	2.7	3.1
Asian course	13	2.8	2.4	1.8

2.3 Instruments

Questionnaire

The questionnaire incorporated the Cultural Competency Assessment Instrument (CCAI) for Health Care Providers[2] (See Appendix 1) and was completed prior to commencing the module and again 6 weeks after completing the module. Using a 5 point Likert–type scale, the instrument is a 27 item scale consisting of two sub-scales designed to measure cultural awareness and sensitivity (CAS – consisting of 11 items) and cultural competence behaviours (CCB – consisting of 16 items). Higher scores are indicative of more positive attitudes and greater frequency of competence behaviours. In a study of cultural competency amongst health workers, the original authors of the scale reported Cronbach's alphas of 0.89 for the overall scale, 0.91 for the CCB subscale and 0.75 for the CAS subscale. Similar Cronbach's alphas were obtained in the present study - 0.87 for the overall scale, 0.88 for CCB and 0.74 for CAS, indicating high internal consistency reliability.

Telephone Interviews

[2] Doorenbos,A.Z., Schim,S.M., Benkert, R. & Borse,N.N. 2005. Psychometric evaluation of the cultural competence assessment instrument among health providers *Nursing Research, 54,*5 324-331.

In addition to completing the CCAI, all participants who completed the questionnaire prior to and following the completion of Module 1 were invited to participate in a short interview in order to gain an understanding of their perspectives on the content and quality of Module 1 and how participation in the course had influenced their thinking and practice. This interview was conducted over the telephone using the interview guide (see Appendix 2) created by the research team within four weeks of the participant having completed the post module questionnaire.

2.4 Procedure

All health professionals completing Module 1 Culture and Cultural Competency between March 1st 2011 and September 31st, 2011, either the classroom-based or e-learning versions of Module 1, were invited to participate in the evaluation via email. Details of enrolments in Module 1 were provided to the research team on a daily basis. Upon receipt of the information, enrolees were emailed a copy of the participant information sheet, which outlined the purpose of the evaluation, what participation involved, and invited them to participate. The email contained a link to the online questionnaire which was hosted by LimeService. It was explained to prospective participants that completion of the questionnaire constituted their consent to participate. Participants clicked on the link and completed the questionnaire online. (Upon completion of the questionnaire, an email was automatically sent to the researchers informing them that an individual had completed the survey.) If the questionnaire was not completed within 24 hours, enrolees were telephoned to check whether they had received the email. Prospective participants were also given the option of completing a hardcopy of the questionnaire if they preferred. In this instance, they were sent a hard copy, which they completed and returned in a prepaid envelope.

Six weeks after completing the Module 1 Culture and Cultural Competency, all participants were emailed and asked to complete the CCAI again online. One reminder email was sent if the post-questionnaire was not completed within two weeks of the first email.

The qualitative arm of the evaluation involved semi-structured telephone interviews (see Appendix 2). All participants completing the follow up questionnaire were contacted via email and/or phone and invited to participate in a brief telephone interview and provided with written information explaining the interview purpose and procedure. Formal consent was obtained from those who agreed prior to completing the interview. Interviews were designed to gather participants' perceptions and experiences of the course, and to give them an opportunity to

give examples of how undertaking the course might have influenced their thinking and/or practice. With permission, interviews were audio-recorded and later transcribed by a trained person. A total of 49 interviews were conducted, 36 with participants who had completed the module online and 13 with those who had completed it face to face.

2.5 Data analysis

Quantitative data

All quantitative data were imported into IBM SPSS (Version 19), a statistical computing software package. Descriptive statistics were generated to provide a profile of participants. Inferential statistics were conducted to test the significance of differences in pre-post scores on the CCAI, and to examine differences in scores as a function of variables: occupation, ethnicity and participation in previous cultural training programmes.

Qualitative data

Interview data were imported into QSR NVivo (Version 8), a qualitative data analysis tool. Following the general inductive approach[3], thematic analysis was applied to qualitative interview data. The general inductive approach allows for dominant and significant themes to emerge. The trustworthiness and reliability of the general inductive approach was tested by an independent researcher re-coding and re-categorising a section, ensuring a similar and consistent assignment from the raw text to each code and category.

3.0 RESULTS

3.1 Impact on Cultural Competence

Quantitative findings

[3] Thomas, D (2006). A General Inductive Approach for Analyzing Qualitative Data. *American Journal of Evaluation, 27*(2), 237-246.

In order to determine the impact of CALD Module 1, a two phase analysis was undertaken. In the first instance, repeated measures MANOVA were performed on the total scores and on the behavioural and attitude/sensitivity subscale scores of the Cultural Competence Assessment tool collected at two points in time; prior to, and 6 weeks after the completion of Module 1. Independent variables entered into the analyses included participants' ethnicity, occupation, whether they had participated in previous cultural training, and mode of delivery, i.e. face to face or online. Due to the small numbers in some groups, some variables were collapsed, thus NZ European formed one ethnic group and was compared to all other ethnic groups. Similarly, occupations were collapsed into two groups, with nurses and doctors in one group, which was compared to all other occupations.

Impact of CALD Module 1

Analysis of total scores indicated that there was a significant increase in pre and post module scores (maximum possible score =135 : pre M =100.04, SD = 9.99; post M = 109.42, SD = 9.61; $F_{(1,88)}$= 62.49, *p* .000). Total scores did not differ as a function of any of the independent variables.

Similarly, total scores on the two subscales were analysed. While there was a significant, positive change in behavioural scores on the CCB subscale with post assessment scores following completion of Module 1 exceeding pre assessment scores (maximum possible score = 80: pre M = 59.37, SD = 8.60; post M = 65.36, SD = 7.77; $F_{(1,88)}$ = 38.15, p.000), there was no corresponding significant change on the attitude and sensitivity subscale (CAS) total scores (maximum possible score = 55): pre M = 43.36, SD = 3.75; post M = 44.05, SD = 3.80; $F_{(1,88)}$ = 2.23, p.14. However, scores on this subscale did differ significantly depending on whether or not participants had had previous cultural training. That is, while participants who had had previous cultural training did not differ significantly with respect to their scores on the attitude and sensitivity subscale from those who had not had previous training *prior* to undertaking Module 1, analyses showed that *post* module, those who had had previous exposure to cultural training made significantly larger gains than those who had had no previous cultural training.

Table 4 showing changes in pre and post module scores as a function of previous cultural training

Scores	Previous cultural training			
	Yes		No	
	M	SD	M	SD
Pre Module	43.76	3.75	42.92	3.80
Post Module	45.00	3.67	43.21	3.74
$F_{(1,104)}$	1.32		6.24	
p	.25		.014	

Pre and post module scores on individual items on behavioural and attitudinal/sensitivity subscales

In order to assist in identifying the areas in which significant behaviour and attitudinal change occurred pre and post, paired *t* tests were conducted on each item making up the two subscales. This analysis is summarised in Table 5 and Table 6.

Table 5 showing mean pre and post module item scores on behaviour subscale

Item	M	SD	t	df	p
I include cultural assessment when I do client or family evaluations					
Pre	3.44	1.08	-6.06	107	.000
Post	3.98	0.83			
I seek information on cultural needs when I identify new clients and families in my practice					
Pre	3.51	0.83	-4.52	107	.000
Post	3.90	0.85			
I have resource books and other materials available to me to help me learn about clients and families from different cultures					
Pre	2.97	0.99	-4.78	107	.000
Post	3.48	0.96			
I use a variety of sources to learn about the cultural heritage of other people					
Pre	3.28	0.81	-5.87	107	.000
Post	3.81	0.71			

Item	M	SD	t	df	p
I ask clients and families to tell me about their own explanations of health and illness					
Pre	3.47	1.03	-4.09	107	.000
Post	3.91	.0.89			
I ask clients and families to tell me their expectations of care					
Pre	3.60	1.07	-3.36	107	.001
Post	3.94	0.93			
I avoid using generalisations to stereotype groups of people					
Pre	4.11	0.93	-3.97	107	.000
Post	4.49	0.65			
I recognise potential barriers to service that might be encountered by different people					
Pre	4.06	0.64	-1.89	107	.063
Post	4.19	0.69			
I act to remove obstacles for people of different cultures when I identify such obstacles					
Pre	3.99	0.91	-5.23	107	.000
Post	4.42	0.71			
I act to remove obstacles for people of different cultures when clients and families identify such obstacles to me					
Pre	4.30	0.82	-4.09	107	.000
Post	4.59	0.66			
I welcome feedback from clients about how I relate to others with different cultures					
Pre	4.28	0.98	-3.96	107	.000
Post	4.62	0.67			
I welcome feedback from my co-worker about how I relate to others with different cultures					
Pre	4.33	0.95	-2.50	107	.014
Post	4.55	0.75			
I find ways to adapt my services to client and family cultural preferences					
Pre	4.03	0.75	-3.35	107	.001
Post	4.26	0.65			
I document cultural assessments					
Pre	2.82	1.09	-6.35	106	.000
Post	3.38	1.07			

I document the adaptations I make with clients and families					
Pre	3.29	1.15	-4.62	107	.000
Post	3.69	1.03			
I learn from my co-workers about people with different cultural heritages					
Pre	3.98	0.84	-2.24	1.07	.027
Post	4.18	0.68			

Overall, the mean item scores (higher scores indicate more positive behaviours) indicate that participants 'agreed' or 'strongly agreed' with the statements. On two items – "availability of resources" and "documenting cultural assessment" - the pre scores indicate that, on average, participants tended to disagree with the statements. However, there were statistically significant increases between pre and post intervention scores on all but one item, 'recognising potential barriers to service'. Nevertheless, the change for that item was in a positive direction.

Table 6 showing mean pre and post module item scores on attitude and sensitivity subscale

Item	**M**	**SD**	**t**	**df**	**p**
Race is the most important factor in determining a person's culture (reverse scored)					
Pre	3.01	0.81	-1.62	107	.109
Post	3.18	0.72			
People with a common cultural background think and act alike					
Pre	2.98	0.76	-.0.51	107	.614
Post	3.01	0.67			
Many aspects of culture influence health and healthcare					
Pre	4.37	0.69	-0.49	107	.625
Post	4.41	0.58			
Aspects of cultural diversity need to be assessed for each individual, group and organization					
Pre	4.20	0.82	-3.58	107	.001
Post	4.46	0.53			

Item	M	SD	t	df	p
If I know about a person's culture I do not need to assess their personal preferences for health services					
Pre	3.50	0.54	.403	107	.688
Post	3.47	0.72			
Spirituality and religious beliefs are important aspects of many cultural groups					
Pre	4.42	0.61	.000	107	1.00
Post	4.42	0.69			
Individuals may identify with more than one cultural group					
Pre	4.34	0.60	-282	107	.779
Post	4.36	0.60			
Language barriers are the only difficulties for recent immigrants to NZ					
Pre	3.50	0.72	-.332	107	.741
Post	3.53	0.79			
I understand that people from different cultures may define the concept of "health care" in different ways					
Pre	4.41	0.49	-.271	107	.787
Post	4.43	0.64			
I think that knowing about different cultural groups helps direct my work with individuals, families, groups, and organizations					
Pre	4.39	0.75	.249	107	.804
Post	4.37	0.68			
I enjoy working with people who are culturally different from me					
Pre	4.21	0.77	-1.40	106	.164
Post	4.33	0.75			

In contrast to the behavioural items, there was only one significant shift in pre compared to post module scores on the items related to attitudes and sensitivity, that being the item relating to the belief that "aspects of cultural diversity need to be assessed". It should be noted that,

overall, the scores indicate generally positive attitudes prior to completing Module 1 of the CALD programme.

3.2 Participant perspectives on quality and content

Qualitative findings

In this section, the outcomes of the analysis of the interview data are presented with respect to delivery of the programme, quality of resources, useful aspects and practical application. It should be noted that at the time of the interview, in addition to Module 1, 15 participants had completed Module 2, 9 had completed Module 3 and 8 had completed Module 4.

Delivery

Face to face:

Overall, the quality of delivery of the face to face module of CALD 1 was highly regarded. Interviewees indicated that the face to face mode of delivery was well paced, clear and succinct. Furthermore, it was felt that the presenter was very good at presenting the material in an engaging and stimulating manner. One interviewee described the presenter as "*passionate about the topic",* which enabled her to capture participants' attention. The following quotes attest to these views.

> *Clear and stimulating.*
>
> *I thought the delivery was very professional, very well understood, very well outlined.*
>
> *Very, very good. I was impressed with the delivery.*
>
> *The facilitator was skilled, well trained, she took it at a very nice pace, she took time to engage everybody and um you know kept to time. You know, presented well, didn't overload things and enough sort of variety between listening and group work, so I thought it was, well, professionally presented really.*

One strength of the face to face version highlighted by interviewees was its participatory nature - the fact that it enabled active participation with other learners. Interviewees who had undertaken the face to face module relished the opportunity that the face to face option had provided to interact with other participants during the course. These interviewees clearly held a preference for this mode of learning. No less important was the presenter's skill in facilitating

discussion in a constructive way. These points are highlighted in the following quotes from interviewees:

> *It was very good. It was clear, concise, people were kept on track with questions, you know, to keep them from sliding down into a whole lot of personal experiences and self disclosure. [The discussion] was kept on track, so we moved through it at quite a good pace.*
>
> *Really good – I liked the opportunity the face to face [mode] offered to discuss issues with the other members of the class.*
>
> *I definitely thought the face to face was good as you do it with people from other areas. I think the presenter did a very good job.*
>
> *The delivery was great. Good interaction. The tutor was friendly making for an excellent environment for learning.*
>
> *I liked the delivery, it was paced well and it was sufficiently relaxed but sort of engag[ing]. It was smallish groups. I just thought that we were able to participate, it wasn't just being talked at. It was a discussion and I thought that was great as people were able to speak to the floor on their experiences and I liked that the participation made it more interesting than just doing the computer one. That was of value for me, the actual interaction.*

It was felt that the presenter had credibility and knew the topic well, and that the material as presented was relevant. In this respect, the following comment was made by one of the interviewees.

> *Excellent, [name of presenter] was really good. She knows her stuff so well.*

Online:

The online mode of delivery was valued for its simplicity and clarity. In general, those using this mode found it uncomplicated and easy to use. The interactive nature of the website engaged participants and supported learning. The following comments from online participants exemplify these views:

> *Well done, clear and concise.*
>
> *Simple and straightforward.*

I thought the interactive website was good for promoting learning and keeping me interested. It was also good that I could pause it and it would save my progress.

It was good because it was e-learning and I could do it at my own pace. The website is simple to navigate and I was able to print out the paperwork book and jot things down on it as I progressed through the online course.

It was easy, practical and suited my timing well.

Moreover, the online format enabled in-depth learning through the diverse methods and teaching tools employed to convey material.

I thought it was quite good. I liked the diverse um, methods that you used, having the videos, or having exercises and things like that.

Delivery was excellent – much more in-depth than I had expected of an online course.

A range of delivery methods meant that my interest was held all the way through the program and it was great to see such an effective combination of teaching tools implemented.

An important strength of the online mode of delivery was the fact that learners could complete the course in their own time. This was especially valued by some:

Really good. Could do it in my own time without pressure and could pick up where I left off if I couldn't complete a section all at once. Was a great help.

The online format was a real plus because I could go back to it. Even though I had time blocked out to do it, things come up.

It was great that you were able to come back to it as when you're busy you might only have 20 minutes to get some done. And then when you came back to it, it took you straight to where you had finished.

Learners were satisfied with the pace of delivery and presentation of material in the online mode, which provided particular benefits such as the facility to review material already encountered and opportunities to reflect on what one was learning. Quotes from learners presented below reflect these sentiments.

It was very precise, it was very slow, it didn't quickly rush things. It was all taken in step

by step. I thought that was very good. [The pace was good] and also, when you moved on to the next module, you could kind of go back and be reminded of something that was in the previous module. I thought that was good. So, yes, I thought the delivery was very good.

It was good. I liked the way it was all laid out. And it made you reflect because you had to take time out during the module.

For individuals who did not have sufficient time available to take half a day out to undertake a course, the online version enabled them to do the course without impacting negatively on their schedule.

It was a good idea to have something online that we could dip into when we had a few spare minutes.

Great that you are able to pick it up where you left off. Makes it flexible when trying to complete in the work environment.

This is the first e-learning course I have done. It is very interesting seeing the new technology being employed so creatively to facilitate on-going learning. I was pleased that I was able to access the site relatively easily. I'm feeling inspired to sign up for another e-learning course. This is particularly helpful for those of us who do night-shift and are sleeping when most of the face to face courses are on.

I've got a busy job so it was great to be able to access it in my own time, so I enjoyed that. It's frustrating when you have to go to trainings but don't have time to fit them in.

One interviewee felt that there were inherent risks in using online resources as sometimes computer systems and/or access may not be sufficient to enable access to these.

I found that the videos worked but it's a risk on work computers that they won't play on the network.

Some participants noted that they had experienced technical difficulties but these appeared to be related to technical failures associated with the local computer system rather than the online course itself. Nevertheless, this did appear to impact on some interviewees' experience of the course.

I had a few technical difficulties because the computers I was using were Sunrays and they have no sound which you needed for voice recordings. So it might have been helpful to have, when you first start, well, what happened was I had to keep going in and out to find a different computer, so even if it said at the start you will need to listen and you need a PC rather than a Sunray. So that delayed things and it became a bit difficult.

We have limited access to computers with sound so it meant that completing the course online required some negotiation.
Poor – may have been our computer but sound quality of video was very difficult to understand.

One online participant mistakenly believed the 'save' function of the online module did not work as her responses were not recorded upon exiting the module. However, the online module does not have a function to save information. Since receiving this feedback from participants, a note has been added to the online module informing people of this to avoid people thinking information is saved on the system. Instead, learners are encouraged to make notes in their printed workbook.

Another participant noted difficulties with delivery of the online material. Again, this appeared to be an isolated incident:

Some of the links didn't work and I needed to log on a few times. I had a new laptop so it wasn't because of the computer. I've done some of the other CALD courses and they were better.

In summary, the overwhelming majority of interviewees held very positive opinions of the quality of programme delivery. This held for both the face to face and the online modes of delivery. It appears that in most cases the recipient of the training was able to choose the mode of delivery. Further, for the most part, personal preference and learning styles appeared to dictate whether an individual undertook the face to face or online mode of delivery, which in turn impacted on how satisfied they were with delivery. Where learners did not get to choose and ended up undertaking the course not in their preferred mode, they were less satisfied. However, this did not appear to be a problem with the quality of delivery per se, but rather

having to undertake the course in a mode less conducive with their learning style or not of their preference. Thus, no differences in quality between the two modes of delivery were detected.

Quality of content and resources

Interviewees were asked for their opinions on the content and quality of resources with respect to Module 1. A range of comments were made reflecting positive opinions on both content and resources. In general, the content was considered to be relevant, interesting, thought provoking and easy to follow and the resources were found to be useful and effective. The following quotes provide examples of these.

Covered the right things.

I thought that the content was great.

The content was relevant to the DHB cultural policy and the needs assessment.

The course content was interesting, used a variety of media, and easy to understand.

Yes, the course content was very good, made you think about things that you normally wouldn't think about, so that's good, bringing to light stuff that's, yeah, that a normal person just walking around doesn't really think about.

Highly relevant to the different situations that I work in. It was very informative and I can use the information in other areas.

Well, I liked it. It covers an awful lot of stuff, and I think it covers it well. I'm glad I've got the book to go with it...it was explained as we went through, with people who have actually experienced some of those interactions. I felt that it was really useful. It appears to be not very dense but in actual fact there is a hell of a lot there and I liked it, I liked the way it was laid out too.

Addressed areas well and met all my objectives. Liked the pdf workbooks and the online written components.

It was very intensive and right to the point and I like that, so, the content was really good and it just made me think where my thoughts come from, and how the other person might be thinking and then sort of thinking about finding the middle ground.

The content was exactly what I wanted, a good mix of theoretical and practical information with the right amount of testing and opportunity for reflection.

Workbooks were really good. The online resources that are on the website to access, I've used lots of it and even started up a language folder with resources in it at the practice here.

The booklet was good to jot down your thoughts.

It was really nice. Easy to go through the books. And it was nice to get a response saying "well done".

The workbook for CALD Module 1 was really good and useful.

The video scenarios were considered to be useful and of a high quality:

I liked the videos. I thought they were really good and I liked that they showed demonstrations between people.

The scenarios were good.

I really liked it. The video examples were very helpful even though they were role play. They were real enough to get the point across, especially if you don't work with those patients. It illustrated points really well and made it interesting. I learnt that body language was really important and you need both the audio and visual, the unspoken is important.

The video scenarios are very effective way of delivering the message and points of CALD course.

The face to face version may offer added benefits compared to the online version where clarification of content is required as it provides the opportunity to discuss and clarify issues with learners. One instance of this was recounted in which the mode of delivery impacted on perceptions of content quality. In this situation, the content presented did not match the individual's experience. However, because this occurred in the face to face learning situation, this could be dealt with directly. The skills of the presenter, combined with the mode of delivery provided an opportunity to discuss the discrepancy to the satisfaction of the learner.

I thought the, she used her PowerPoints, you know, really well to illustrate. I thought, yeah, the content was really clear. There was just at one point, the video about a

woman and it was to do with fasting and being pregnant so there was a bit of a kind of debate on whether that was actually correct, you know, culturally correct, 'cause they had the woman saying she had to fast where as my experience as a midwife was that women did not have to fast, you know, that it was actually one of the things that let them off so, but what was really good for that was that it was good discussion, and then the facilitator followed up, took it to people and then emailed us all on the response. So you know, it was responsive training. I thought the videos were well done, you know they really gave a good, that really nice culturally sensitive practice.

Only one interviewee felt that the scenario content was unrealistic.

Not much I wasn't aware of already. They exaggerated - I hope - the lack of knowledge of one of the actors, and had an unlikely practice 'guru' who made it all seem a bit unreal.

Although most interviewees were satisfied with the content, a few possible improvements were noted by some respondents. These included increasing the amount of content, increasing the variety of the content of the video scenarios (e.g. to include less medically-focussed material),

I thought it was great, it was very easy to understand, um, easy to deal with and it wasn't too long in that you spent hours and hours doing it, but I think it probably could've been a bit more, um, maybe a bit more content involved. The content was pretty good, but I do think it seems to be a bit focused towards medicine, and I mean I'm doing community work where you're out in their homes so the context is different, but I think it still gave really good examples.

Would have maybe liked a broader range of videos available to view. Maybe some working with family groups, community setting and a different range of cultures available.

It would be nice to have a little bit maybe on Middle Eastern culture just because it dealt with primarily Asian which is a huge part of cliental but it would be nice if there

was a little bit more diversity.[4]

I do think that it would be nice if there was a community based example[5] *rather than coming in to see the doctor...So possibly just if there was a different example available, or just, like this is an example of a family coming into your space but what about when you go into their space?*

Adequate, but... maternity patients generally are well people. At least one example of a maternity patient could be included.

Respondents were generally highly satisfied with the quality of programme content and materials, whether experienced face to face or online. Overall, respondents found the content to be clear and easily understood, and found the resources provided a good variety, offering learners multiple ways of accessing relevant information.

Most useful aspects

Interviewees were asked what they thought the most useful aspects of the course were. While some were unable to single out a particular aspect, others noted particular aspects, mostly to do with the increased cultural competency the course instilled and the relevance of the cultural information imparted. The following represent the main themes from feedback regarding the most useful aspects and learning: the inclusion of cultures not usually covered in trainings; the broad scope of cultural aspects covered; the depth of cultural material provided; culturally sensitive approach and language; practical, culturally relevant information; cultural competency developed; increased cultural sensitivity imparted by the course; information readily applicable to practice; checking up with clients regarding differing cultural expectations. The following quotes provide examples of these perspectives.

Often in training it's about Maori and Pacific Island and Asian and African aren't usually included.

It reinforced and taught different aspects of the culture.

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[4] A Middle Eastern culture scenario was provided in the CALD 1 Module and Middle Eastern culture-specific scenarios are available in CALD Module 3 Working with Refugee patients and other newly developed modules, CALD 7, 8 and 9 (see footnote p.7). Module 1 was designed to provide general and practical skills to work cross-culturally with a few scenarios and learners are expected to continue to learn more from CALD Modules 2-9 to gain more skills working in different settings with different cultural groups.

[5] Community-focused scenarios are found in other CALD training modules – see the suite of courses available in 2012.

The CALD Module 1 is the most useful as I learned how to be culturally competent. Though I believe that I have been culturally sensitive being an Asian myself and been working in the Middle East for 24 years in total, I already had the skill but the module has deepened my understanding of the definition of terms. It helped me a lot that with this new knowledge I acquired through the CALD I am even more sensitive and culturally competent in understanding my patients.

It gave me some practical examples to implement in my practice as well as introducing some key information about cultural perspectives of which I was unaware.

I found the examples shown of how to relate to patients with different cultural needs relevant; i.e. working with Muslim patients. Because it made me more aware of how we can generalize in our thoughts and in how we work with patients of differing cultures compared to ours.

[It helped me] just in terms of being sensitive to other people anyway regardless of their ethnicity and trying to read them and their discomfort, if maybe you are actually producing something that may not be appropriate or be uncomfortable for them.

The specifics of looking at people's facial expressions and the empathy and some things that you touch and don't touch, that sort of specificity was what I got. On a basic level I was aware but the examples were very useful and the differences in how you can actually talk to somebody.

Although I work within the community setting, I found the knowledge and values very easily relatable within my practice.

I have to say that sometimes I find it frustrating working with people from different backgrounds so by going through the CALD information it just sort of opened my mind a little bit more to why I might be feeling that way and made me realize that some of my thoughts and feeling, where they come from and how that impacts on my practice and how that may impact other people and their healthcare outcomes. So it's just being more conscious of how I feel and then how maybe what I say or do may impact on that person. So it is just trying to find the middle ground and the best outcome.

In general it amazed me how much more of a holistic approach to people [is needed], um, opening my eyes to the cultural needs and beliefs of my patients. I felt being

European, being very ignorant of other cultures and sometimes what we perceive as inappropriate in our culture is absolutely acceptable in somebody else's.

Clearly, interviewees experienced a range of useful aspects as a result of participating in Module 1 that they felt contributed to development of their cultural competence in dealing with CALD patients. The following section describes how participants have put that competence into practice.

Application to practice

Interviewees were asked to recount an example of how they had applied the information they had learned to their practice. Many had difficulty thinking of a specific example, but were able to describe various ways they had found the information they had learned applicable to their practice. These included, knowing how to establish rapport with culturally diverse clients; improved communication with culturally different clients; increased cultural sensitivity and awareness; making allowances for cultural difference. The following quotes provide examples of these.

It has helped me establish rapport with my clients – I now ask them about their notions of health, family involvement - tell them something of my own background – it builds trust.

It has had a significant impact on my communication with clients over the last two weeks at least. I have had the opportunity to work with a Tongan family and feel the cultural training really supplement my OT skills and delivery of info. I think I got more out of the session/treatment than I would have not having completed the recent training.

I think I'm more aware that some cultures don't like being seen by a male doctor. I guide them through that and go through the journey with them. It there are no female doctors on duty I will let them know when there next will be, or if I think they need to be seen straight away I will work through that with them.

A Burmese family who attend our practice, I have now used an interpreting service as I'm more aware of how I could misunderstand them and vice versa. I feel I am a better listener as I am thinking more about the client's background.

I think it would have to be the scenarios that were played as to how you could interview

someone versus how it would be more culturally appropriate to interview someone. I found that very, very helpful so that now when I do interact, especially when maybe it's dealing with a touchy subject or, yeah, just better interviewing techniques and being more perceptive in that way and I guess...that the biggest things I've pulled away from doing this is that I was always of the opinion that you should treat others as you would like to be treated... but just by going through this information I realized that, that is not necessarily the case as some people come from a collective environment and their family would make the decisions, and I would get frustrated at that so just realizing that independence does not exist in all societies...so that's been the most helpful thing for me to not be maybe so impatient and frustrated, just realizing that difference.

I try to be mindful of cultural issues in my work and have recently been involved with a Chinese client who has very limited English and does not understand a great deal of what is going on around her. I have been working with the Cultural team to identify her needs and we have also found an interpreter to complete a personality assessment in Mandarin, as me testing her in English would not be appropriate. We have also considered diet issues and access to culturally specific activities in the community.

I have been much more aware of my preconceptions and cultural biases when interacting with CALD patients since completing the course – it has made me a more sensitive and less judgmental nurse. I take more time to address patients' expectations now that I am aware they may be very different from my own.

We recently had a Somali patient with a fracture. They had been referred appropriately but they came back in and they felt that they hadn't been treated. They had been to the specialist but they hadn't done anything different. They had different expectations so we talked to them about what their expectations were and explained why. It makes me more aware to ask about what the patient is expecting to happen.

I have been more aware of clients that I would have previously assumed to have similar cultures to my own as potentially being different and have tried to ensure that I ask about their needs in a more defined manner.

I think that having that awareness to start with, and you know asking a patient about their culture and the correctness of it in their culture rather than just assuming. So it just made me sort of far more aware, whereas perhaps culture would have been the

bottom of the list of when you're asking a patient questions I now put it much nearer the top. You know, thinking about where they come from, who they are, what their cultural background is and whether the questions that I'm asking seem appropriate for them.

I now start with having good conversation with CALD patients. Sometimes they come and talk about herbal medicines. I have to incorporate this in my triage so the Dr. will be alerted. I see patients that are quiet and shy and I started asking how long they been in NZ and asked how they are integrating with the new society. They just smile and start to be more open in discussing their illness.

Probably the best one I can think of is that we have quite a few people from the Middle East, and, um, the example of the lady that they gave in one of the interviews was her religious beliefs were more important than her health beliefs... I always assumed that the health would take preference but obviously religion in some cultures is extremely more important than health. Recently we've had a person who's fasting come in and explained to them that it's important that the medication is taken three times a day and they said that, no, they couldn't take it during the day times. And it was trying to understand the whole culture that, ok, the religious part is more important than any other and how do we actually deal with this. And it was pretty easily solved where we changed the medication so that they could take it at morning and at night, so we were able to get around the situation that way, but it's the fact you would think that health would come first and in this situation it didn't.

Prior to this course, I was not so bold in talking directly about culture. I would ask people where they were from, check that I was pronouncing their name correctly and ask them to talk to me about their culture, ask how they say some greetings in their language, alert me to any special cultural needs that Detox could ensure were met. However, I now spend more time, on first interaction, talking directly about culture. I note that in some cultures that interactions between males and females are different from those in NZ. Would they prefer a same-sex person to be their primary nurse, for instance? Some cultures are more formal than NZ in interactions between health practitioners and clients. How should I address you? I now get more specific in my questions, rather than more general open-ended questions.

In summary, participants who had undertaken Module 1 believed that they had benefited from the course. They noted a range of useful aspects that they had taken from the course and described various ways in which they had put the cultural competence gained into practice.

4.0 DISCUSSION and INSIGHTS

The findings from this evaluation show that, overall, completion of Module 1 of the CALD programme had a significant impact on participants' cultural competence. That is there were significant increases in overall cultural competency scores following completion of the module

However, the impact differed somewhat according to which aspect reflective of cultural competence was concerned. Specifically, there was no significant change in measures of attitudes and sensitivity when pre and post Module 1 scores were compared, although changes were in a positive direction. The latter finding may not be surprising considering that pre module attitudes and sensitivity levels were higher or more positive, relatively speaking, than pre module behavioural scores (i.e. attitude/sensitivity pre module mean score was closer to a positive ranking - 43.36 where 44 reflected a minimum positive ranking - than the behaviour pre module mean score - 59.37 where 64 reflected a minimum positive ranking), meaning that there was less potential for change in a positive direction for attitudes and sensitivity. However, while, as explained above, the changes in pre – post scores were not significant overall it is interesting to note that the changes in scores as a function of whether respondents reported having participated in previous cultural training or not were. Participants who reported having previous training made significant gains while changes in scores for those with no previous cultural training did not change significantly.

It appears that participation in Module 1 positively impacted on those who had had previous cultural training by reinforcing or consolidating prior learning.

Further, while attitudes were generally positive, participants may not have known how to act on those attitudes, that is, they may not have the practical skills to match. However, by participating in Module 1, they gained the behavioural skills needed to support positive attitudes, hence the observed significant positive change in behaviour.

These quantitative findings are supported by the qualitative findings. Increased positive behaviours and attitudes/sensitivity towards CALD patients were reported by participants.

According to qualitative data, participants found Module 1 to provide many useful aspects with respect to increasing their cultural competency and described various ways in which they had utilised learning in practice. They reported increased knowledge of cultural differences, including values, health beliefs, religious beliefs, gestures and customs, and better skills when interacting and communicating with CALD patients. They also described ways in which their awareness of and sensitivity towards CALD patients had been enhanced. Moreover, according to the qualitative evidence obtained, participants in CALD Module 1 reported a heightened awareness of their own culture and how their own cultural beliefs impacted on how they viewed other cultures different from their own.

Participants' experience of CALD Module 1 was overwhelmingly positive. They reported high levels of satisfaction with the content, programme delivery and quality of resources.

Considering all the data obtained for this evaluation, the CALD Module 1 achieved the aims of delivering a high quality, well designed, interactive, engaging, educational and self-reflective programme, with good quality video scenarios, offering mixed learning options, that enhance learning.

Points for consideration

The following represent various points that emerged during analysis that warrant further consideration:

- Enrolees could be encouraged to undertake the module in the preferred mode as this appears to be an important aspect of satisfaction with the course.It may be necessary to check that enrolees in the online module have sufficient access to a stable computer platform to ensure satisfactory delivery.
- Given that a third of those who enrolled and completed the pre questionnaire did not complete Module 1 within the evaluation period suggests that there may be a need to follow up those who have enrolled but not completed the module within a given time. It would seem that further research with groups might be profitable in identifying the barriers to completion.
- The finding that those learners who had had previous exposure to cultural training had significant gains in the attitude and sensitivity subscale scores on completion of Module 1 suggests that changes in attitudes and sensitivity may be cumulative and thus everyone, irrespective of previous exposure to cultural training, should be encouraged to complete CALD.

In conclusion, while this evaluation only covered Module 1 of the CALD programme, the findings are very positive and, if representative of the programme as a whole, suggest that the programme is meeting its aims. To this end we would suggest consideration be given to routinely administering the Cultural Competency Assessment prior to commencement of the programme and again at the completion of Module 4 in order to evaluate the impact of the overall CALD programme.

Appendix 1: Questionnaire

CALD Cultural Competence Surve

This survey is designed to assess participants' cultural competence. It is to be completed ***before*** and ***6 weeks aft*** completion of Module 1 of the CALD cultural competence training.

Welcome and thank you for taking the time to complete this survey.
The survey should take no longer than 10 minutes to complete.
Every effort will be taken to keep the information you provide confidential.

There are 35 questions in this survey

Demographic details

Demographic details of participants

1 [01]Please provide your full name: *

Please write your answer here:

Please provide your preferred title (e.g., Mr, Ms, Dr., etc.)

We need your full name so we can match your responses pre-CALD training to your responses post-CALD training.

2 [02]What is your age (in years)?

Please write your answer here:

3 [03]Are you male or female?

Please choose **only one** of the following:

- ○ Female
- ○ Male

4 [04]What is your ethnicity?

Please write your answer here:

5 [05]What is your current occupation?

Please write your answer here:

6 [06]Have you previously been exposed to cultural competence education or training? *

Please choose **only one** of the following:

- ○ Yes
- ○ No

Other than the current CALD training.

7 [07]If you answered 'yes' to the previous question, please briefly describe the nature of any previous cultural competence education and how long ago you were exposed to this.

Please write your answer here:

8 [08]Are you completing this survey before, or 6 weeks after, completing Module 1 of the CALD training? *

Please choose **only one** of the following:

- ○ Before
- ○ After

CCA Part 1

CCA Behavioural items

9 [Behav01]I include cultural assessment when I do client or family evaluations. *

Please choose **only one** of the following:

- ○ Always
- ○ Often
- ○ At times
- ○ Never
- ○ Not sure

10 [Behav02]I seek information on cultural needs to identify new clients and families in my practice. *

Please choose **only one** of the following:

- ○ Always
- ○ Often
- ○ At times
- ○ Never
- ○ Not sure

11 [Behav03]I have resource books and other materials available to help me learn about clients and families from different cultures. *

Please choose **only one** of the following:

- ○ Always
- ○ Often
- ○ At times
- ○ Never
- ○ Not sure

12 [Behav04]I use a variety of sources to learn about the cultural heritage of other people. *

Please choose **only one** of the following:

- ○ Always
- ○ Often
- ○ At times
- ○ Never
- ○ Not sure

13 [Behav05]I ask clients and families to tell me about their own explanations of health and illness. *

Please choose **only one** of the following:

- ○ Always
- ○ Often
- ○ At times
- ○ Never
- ○ Not sure

14 [Behav06]I ask clients and families to tell me about their expectations for care. *

Please choose **only one** of the following:

- ○ Always
- ○ Often
- ○ At times
- ○ Never
- ○ Not sure

15 [Behav07]I avoid using generalizations to stereotype groups of people. *

Please choose **only one** of the following:

- ○ Always

- ○ Often
- ○ At times
- ○ Never
- ○ Not sure

16 [Behav08]I recognise potential barriers to service that might be encountered by different people. *

Please choose **only one** of the following:

- ○ Always
- ○ Often
- ○ At times
- ○ Never
- ○ Not sure

17 [Behav09]I act to remove obstacles for people of different cultures when I identify such obstacles. *

Please choose **only one** of the following:

- ○ Always
- ○ Often
- ○ At times
- ○ Never
- ○ Not sure

18 [Behav10]I act to remove obstacles for people of different cultures when clients and families identify such obstacles to me. *

Please choose **only one** of the following:

- ○ Always
- ○ Often
- ○ At times
- ○ Never
- ○ Not sure

19 [Behav11]I welcome feedback from clients about how I relate to others with different cultures. *

Please choose only one of the following:

- ○ Always
- ○ Often
- ○ At times
- ○ Never
- ○ Not sure

20 [Behav12]I welcome feedback from co-workers about how I relate to others with different cultures. *

Please choose only one of the following:

- ○ Always
- ○ Often
- ○ At times
- ○ Never
- ○ Not sure

21 [Behav13]I find ways to adapt my services to client and family cultural preferences. *

Please choose only one of the following:

- ○ Always
- ○ Often
- ○ At times
- ○ Never
- ○ Not sure

22 [Behav14]I document cultural assessments. *

Please choose only one of the following:

- ○ Always

- ○ Often
- ○ At times
- ○ Never
- ○ Not sure

23 [Behav15]I document the adaptations I make with clients and families. *

Please choose **only one** of the following:

- ○ Always
- ○ Often
- ○ At times
- ○ Never
- ○ Not sure

24 [Behav16]I learn from my co-workers about people with different cultural heritages. *

Please choose **only one** of the following:

- ○ Always
- ○ Often
- ○ At times
- ○ Never
- ○ Not sure

CCA Part 2

CCA Awareness and sensitivity items

25 [AS01]Race is the most important factor in determining a person's culture. *

Please choose **only one** of the following:

- ○ Strongly agree
- ○ Agree
- ○ Disagree
- ○ Strongly disagree
- ○ No opinion

26 [AS02]People with a common cultural background think and act alike. *

Please choose **only one** of the following:

- ○ Strongly agree
- ○ Agree
- ○ Disagree
- ○ Strongly disagree
- ○ No opinion

27 [AS03]Many aspects of culture influence health and healthcare. *

Please choose **only one** of the following:

- ○ Strongly agree
- ○ Agree
- ○ Disagree
- ○ Strongly disagree
- ○ No opinion

28 [AS04]Aspects of cultural diversity need to be assessed for each individual, group and organization. *

Please choose **only one** of the following:

- ○ Strongly agree
- ○ Agree
- ○ Disagree
- ○ Strongly disagree
- ○ No opinion

29 [AS05]If I know about a person's culture, I do not need to asses their personal preference for health services. *

Please choose **only one** of the following:

- ○ Strongly agree
- ○ Agree
- ○ Disagree
- ○ Strongly disagree
- ○ No opinion

30 [AS06]Spirituality and religious beliefs are important aspects of many cultural groups. *

Please choose **only one** of the following:

- ○ Strongly agree
- ○ Agree
- ○ Disagree
- ○ Strongly disagree
- ○ No opinion

31 [AS07]Individuals may identify with more than one cultural group. *

Please choose **only one** of the following:

- ○ Strongly agree
- ○ Agree

- ○ Disagree
- ○ Strongly disgree
- ○ No opinion

32 [AS08]Language barriers are the only difficulties for recent immigrants to New Zealand. *

Please choose **only one** of the following:

- ○ Strongly agree
- ○ Agree
- ○ Disagree
- ○ Strongly disagree
- ○ No opinion

33 [AS09]I understand that people from different cultures may define the concept of "healthcare" in different ways. *

Please choose **only one** of the following:

- ○ Strongly agree
- ○ Agree
- ○ Disagree
- ○ Strongly disagree
- ○ No opinion

34 [AS10]I think that knowing about different cultural groups helps direct my work with individuals, families, groups and organisations. *

Please choose **only one** of the following:

- ○ Strongly agree
- ○ Agree
- ○ Disagree
- ○ Strongly disagree
- ○ No opinion

35 [AS11]I enjoy working with people who are culturally different from me. *

Please choose **only one** of the following:

- ○ Strongly agree
- ○ Agree
- ○ Disagree
- ○ Strongly disagree
- ○ No opinion

Thank you for completing this survey!
01.01.1970 – 01:00

Submit your survey.
Thank you for completing this survey.

Appendix 2

Cultural Competence Interview Questions

Questions relating to CALD 1: Culture and Cultural Competency Course

1. Did you complete the face to face or e-learning CALD 1: Culture and Cultural Competency course?

2. Did you find the course content useful and relevant to your practice and working with CALD patients or clients?
    - If YES, then what aspects were useful and relevant, and why?
    - If NO, please specify why not?

3. Can you tell me what you thought of the course in terms of quality, and why? (delivery and content)

    Delivery?

    Content?

4. What could be improved? (delivery and content)

    Delivery?

    Content?

5. Please give me an example of how you have applied the information and skills you have gained from the course in practice when working with CALD patients or clients?

6. Which other CALD cultural competency courses have you completed, for example
    - CALD 2: Working with migrant patients
    - CALD 3: Working with refugee patients
    - CALD 4: Working with interpreters
    - Others (please specify): Cultural training …..