



# **Cultural Competence Training in Mental Health:**

**Evaluation of a 6-module course as a component  
of service development**

**Yvonne Stolk, Nadya Kouzma, Prem Chopra, Daryl Oehm and Harry Minas  
Victorian Transcultural Psychiatry Unit**



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## Executive summary

In 2009 the Victorian Transcultural Psychiatry Unit (VTPU) developed a 6-module training program for mental health professionals entitled, *Culturally Competent Mental Health Service Provision for a Multicultural Society*. The course was developed and delivered in partnership with the Victorian Foundation for Survivors of Torture (VFST) and AdvocacyDisabilityEthnicCommunity (ADEC), and with the assistance of the VICSERV Training Unit. The training program modules were offered individually or as a complete course, and included:

- Module 1. Migration, acculturation and identity: Influences on mental illness
- Module 2. Values, the sense of self and emotions across cultures
- Module 3. Communicating effectively across cultures: Working with interpreters and communication with culturally and linguistically diverse (CaLD) consumers and carers
- Module 4. Understanding beliefs across cultures and negotiating alternative explanatory models of mental illness
- Module 5. Cross cultural risk assessment and development of a cultural formulation
- Module 6. Working within organisations to improve responsiveness to CaLD clients.

To investigate the effectiveness of the program, the VTPU developed a multi-modal quantitative and qualitative pre- and post-training approach to evaluating changes in mental health professionals' cultural competence and organisational responsiveness.

## Findings

Participants included 92 professionals from Victoria's child and adolescent, youth, adult, and aged persons' and other mental health services (MHSs), psychiatric disability rehabilitation and support services (PDRSSs) and other community support organisations. The learning program was developed as part of a service development and capacity building initiative involving two area mental health services and VTPU'S Cultural Portfolio Holder program. A total of 33 participants completed all six modules.

### *Cross-cultural confidence and organisational responsiveness*

A measure of Cross-Cultural Confidence in Mental Health Practice and Organisational Responsiveness (CCMHP), administered at the start and completion of the course, showed that there was a significant increase in participants' mean self-ratings on a Cultural Competence sub-scale following training, and an increase approaching significance in ratings on the Cultural Practice sub-scale.

### *Cross-cultural case study*

In a second pre- and post-training measure participants were required to write brief qualitative open-ended responses to a CaLD Case Study regarding cultural factors relevant to assessing and treating the client. Thematic analysis of responses showed

that the number and range of responses increased significantly following training, and the content of the responses shifted from demographic background factors of the client to a greater focus on pre- and post-migration experiences, and settlement issues.

#### *Participant background factors*

Investigation of both CCMHP scores and Case Study responses showed that changes in mean scores occurred regardless of participants' background, such as profession, years of work in mental health, type of mental health service, previous cross-cultural training, cultural portfolio holder role, or CaLD background.

#### *Post-training feedback and reflective comments*

Immediately following each module trainees completed Post-Training Feedback Forms, rating the relevance/usefulness of course content, the case studies presented, activities and handouts. On each of these aspects of the course participants gave consistently high mean ratings of 4.4 to 4.8 (on a scale of 1 *Not relevant/useful* to 5 *Very relevant/useful*) for all six modules. The most frequent post-training qualitative response theme regarding the usefulness of the course was *All 6 modules really useful, balanced, enjoyable; well-presented; looking forward to implementing it*. Useful changes were also recommended for improvements relating to course content, duration and activities.

Qualitative reflective comments were also invited immediately following each module. These generally endorsed the training approach and the value and relevance of the content in developing cultural competence, identified opportunities for development of their services' cultural responsiveness, and for collaboration with CaLD-related agencies. Participants also recognised the importance of service leadership in implementing change. The VTPU, in partnership with managers and other key staff, has developed a range of strategies to facilitate implementation of service change and to integrate learning from the course across all levels of mental health service delivery, in the context of comprehensive cultural competence development strategies.

#### *Follow-up interviews*

Follow-up telephone interviews were conducted 4 – 7 weeks following completion of training, with 17 participants who had completed all modules. Most respondents indicated the training had enhanced their work with culturally diverse clients, having acquired a greater understanding of issues faced by CaLD clients and carers, and developed specific skills such as cross-cultural assessment, and working with interpreters. Most respondents also expressed increased awareness of the need to be involved in developing their services' cultural sensitivity, while recognising that this would be a longer-term project.

## **Conclusions**

Findings from the evaluation of VTPU's course in *Culturally Competent Mental Health Service Provision for a Multicultural Society* clearly demonstrate that participants' self-rated cultural confidence increased following training, as did their understanding of the cultural issues that might influence a CaLD case presentation, suggesting



increased awareness and knowledge, and the potential for increased skills in practice. Participants rated the course as relevant in its content and interesting in its training approach, and identified opportunities for development of service responsiveness and CaLD community development. The benefits of the course applied regardless of the participants' experience and background.

The implication of the findings of this evaluation is that CaLD service users and their families are likely to benefit in terms of improved service access, treatment quality and equity when mental health workers participate in this course. As a major proportion of Victoria's mental health workforce is still to undertake such training, it is recommended that the course continues to be delivered, taking account of some of the changes recommended by participants. Moreover, in view of the evident benefits reported by participants, and as suggested by some respondents, it is recommended that some level of mandatory cultural competence training be incorporated in the professional development of all mental health professionals.

## Background and literature review

The Victorian Transcultural Psychiatry Unit (VTPU) was established in 1989 within Victoria's Office of Psychiatric Services. A state-wide service, the VTPU evolved from a small clinical service, to one that supports specialist area mental health services (AMHSs) and psychiatric disability rehabilitation and support services (PDRSSs) in working with consumers, carers and communities from culturally and linguistically diverse (CaLD) backgrounds throughout Victoria. Currently the VTPU is funded by the Mental Health and Drugs Division of the Victorian Department of Health and is administered by St Vincent's Hospital.

In 2006, people who were born in countries where English was not the first language comprised 17.6% of Victoria's population (or 869,935 persons; Australian Bureau of Statistics, 2006). Research has shown that CaLD communities have a lower rate of access to mental health services than the Australian-born population, and disparities exist in service provision (Klimidis et al., 1999; McDonald & Steel, 1997; Stolk, Minas & Klimidis, 2008). The VTPU's mission is to strengthen the capacity of Victoria's mental health system to provide effective, equitable and culturally appropriate services to Victoria's CaLD population. This includes the provision by the VTPU of cross-cultural training to the mental health workforce to enhance their competence in working with CaLD communities, as required by Victoria's Department of Human Services' (DHS, 2006) *Cultural diversity plan for Victoria's specialist mental health services*. It is also consistent with Standard 6 of the Department of Health's (DoH, 2009) *Cultural responsiveness framework*, which stipulates that, "Staff at all levels are provided with professional development opportunities to enhance their cultural responsiveness" (p. 6). The provision of culturally competent care requires knowledge of cultural values, beliefs and practices if "an effective clinician-patient relationship" is to be established, and if misdiagnosis, inappropriate treatment and noncompliance are to be avoided (Bhui, Warfa, Edonya, McKenzie & Bhugra, 2007, DHS, 2006, p. 15).

### Cultural competence

Cultural competence has been variously defined, depending on the service context, but a broad definition is provided by Bean (2006) who states that "an important element in the development of cultural competence" is "cross-cultural training, which aims to develop the awareness, knowledge and skills needed to interact appropriately and effectively with culturally diverse customers and co-workers" (p. 2). More specifically, Lefley and Pedersen (1986) propose that cross-cultural training should convey:

- 1) awareness of the trainees' own cultural attitudes, including those of mental health services;
- 2) knowledge about the relationship between mental health and culture; and
- 3) skills that enable the trainee to act on the insights gained.

Bhui et al. (2007) identify these elements of cultural competence as involving a developmental process whereby the practitioner moves from a self-reflective "cultural awareness to improved cultural knowledge and ... skills through encounters" (p. 7).

Because of the proliferation of definitions of cultural competence, the Victorian DoH

(2009) prefers the term “cultural responsiveness”, defined as “the capacity to respond to the healthcare issues of diverse communities” (p. 4). Nevertheless, the elements of awareness, knowledge and skills that underpin the definition of cultural competence provide greater specificity at a level that enables mental health professionals’ capacities to work effectively with CaLD individuals to be evaluated, and these concepts are retained for this project.

In the context of implementation, broader dimensions of cultural competence are defined, incorporating the view that “cultural competence is a goal for professionals, agencies and systems” (National Technical Assistance Center for State Mental Health Planning [NTAC], 2004, p.6). Implementation is a multi-level process that addresses interactions within the system as well as interactions with CaLD communities and related agencies (NTAC, 2004). Within the service, cultural competence is evidenced at the levels of policy development, the service delivery organisation, and the clinical practitioner (NTAC, 2004).

## **Review of the VTPU**

In 2009, the VTPU conducted a review of its mode of operation and strategic organisational directions. With a renewed interest in five key areas, the focus shifted to developing and maintaining long term relationships with services with the aim of building local capacity. These areas include: Service Development, Education and Training, Consultation, Partnerships; and Research and Evaluation. In light of this shift, the VTPU reached an agreement with two AMHSs to pilot and evaluate its newly developed training program, and its capacity-building initiatives. These sites provided the VTPU with the opportunity to monitor and benchmark strategies that produce the most effective and sustainable outcomes. This report focuses on the evaluation of the new course.

## **The new cultural competence course**

The 6-module course, entitled *Culturally Competent Mental Health Service Provision for a Multicultural Society (CCMHSP)*, was developed and delivered by the VTPU, in partnership with the specialised service for refugees, the Victorian Foundation for Survivors of Torture (VFST), the PDRSS, AdvocacyDisabilityEthnicCommunity (ADEC), as well as with the assistance of the peak PDRSS body, the VICSERV Training Unit. The course was delivered on three occasions in 2009 in regional and metropolitan locations to ensure equitable access to mental health service providers across Victoria. The modules were presented by various staff from the above agencies on one full day per month over a 6-month period. The six modules, which are listed below, were offered individually or as a complete course:

- Module 1. Migration, acculturation and identity: Influences on mental illness<sup>1</sup>
- Module 2. Values, the sense of self and emotions across cultures
- Module 3. Communicating effectively across cultures: Working with interpreters and communication with CALD consumers and carers

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<sup>1</sup> Delivered in partnership with the Victorian Foundation for the Survivors of Torture.

- Module 4. Understanding beliefs across cultures and negotiating alternative explanatory models of mental illness
- Module 5. Cross cultural risk assessment and development of a cultural formulation
- Module 6. Working within organisations to improve responsiveness to CaLD clients<sup>2</sup>

In developing course learning objectives, the cultural competencies - or cross-cultural awareness, knowledge and skills - that each module aimed to instil, were specified. Content for the course was based on training needs analyses of mental health clinicians by Andary (1998), Baycan (1997), Miletic et al., 2006, and Stolk (2005), and relevant national and state practice and service standards (DoH, 2009; DHS, 2004, 2006; National Mental Health Education and Training Advisory Group, 2002). In addition, content for Modules 3 and 6 was developed by a VTPU-led reference group that specifically sought consumer, carer and PDRSS perspectives. The content and sequencing of the modules reflected cultural issues in the pathway to and within mental health services for CaLD communities, including the CaLD client and worker relationship, assessment, treatment, and organisational and community linkage issues. Teaching methods included: interactive exercises to raise cultural self-awareness, and didactic lectures interspersed with case studies, role-plays, DVD presentations, as well as a diversity of presenters, including guest speakers.

VFST developed module 1 in partnership with the VTPU and continue to facilitate delivery of the module with support from VTPU staff. The module was delivered to include specialist content to enable mental health staff to develop an understanding of the psychological effects of torture and refugee experiences, and the skills required to deliver appropriate services to clients in care and recovery who experience related trauma.

ADEC and the VICSERV Training Team provided partnership support in the development of module 6, addressing service development and community development content. ADEC continue to contribute their expertise and facilitate the community development component of the course in partnership with VTPU staff. The professional and experiential background of the training team included consumer advocacy, carer consultancy, occupational therapy, clinical psychology, social work and community development.

To ensure a comprehensive evaluation, the VTPU developed a multi-modal qualitative and quantitative approach to assessing changes in mental health professionals' cultural competence and organisational responsiveness.

## Literature review

An Australia-wide survey of 93 government and community organisations by Bean (2006) found that the 39 Cross-Cultural Training (CCT) programs that they delivered consistently achieved their objectives. Pre-, post-training and follow-up evaluation

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<sup>2</sup> Delivered in partnership with AdvocacyDisabilityEthnicCommunity (ADEC)

measures showed significant improvements in awareness and knowledge of cultural factors relevant to their clients, and in issues of organisational responsiveness. However, the CCT programs did not demonstrate transfer to practice in the workplace as the programs had been relatively brief (an average of six hours) and lacked organisational measures of cultural competence (Bean, 2006).

In a pre- and post-training evaluation of a 2-day workshop on Cross-cultural Psychiatric Assessment (CPA) for Victorian mental health Crisis Assessment and Treatments Teams (CATTs), Stolk (2005) found that clinicians' knowledge and self-rated cross-cultural confidence and competence increased significantly from pre-training to immediately post-training, an increase that was maintained at 6-months' follow-up. Qualitative analysis of case reports, however, showed no marked improvement in incorporation of cultural factors that might influence CaLD client presentation. A long-term impact evaluation six months following training found, contrary to predictions, no significant decrease in involuntary admissions of CaLD patients to acute inpatient units (Stolk, 2005). Although the CPA program aimed to maximise the effect of the training by training all staff in a team<sup>3</sup>, the lack of significant change in both case reports and involuntary admissions for CaLD clients may be attributable to the absence of further specific strategies to address organisational responsiveness. Moreover, there is suggestive evidence that cultural barriers and stigma (Rooney, O'Neil, Bakshi & Tan-Quigley, 1997) may result in CaLD clients presenting to mental health services only when severely disordered and requiring involuntary admission (McDonald & Steel, 1997; Minas, Lambert, Kostov & Boranga, 1996; Stolk, 2005; Stolk et al., 2008).

A comprehensive multi-modal outcome evaluation of cross-cultural training was undertaken by Lefley (1986a) of an 8-day course for mental health professionals. Measurable objectives for the trainees were "significant increases in cultural knowledge, comprehension of cultural values, and therapeutic effectiveness" (Lefley, 1986b, p. 94). Scores on short-range knowledge evaluation measures increased significantly following the course (Lefley, 1986a). To evaluate transfer to clinical practice Lefley (1986a) used pre- and post-training videotape recordings of mental health trainees' therapeutic intervention skills in a scripted scenario as a short-range outcome measure. Trainees' videotaped problem-solving skills, rated by over 1,000 students, and verified by staff clinicians, improved significantly following training (Lefley, 1986a). A longer-term impact evaluation found increased service access and reduced attrition by minority clients six months following training (Lefley, 1986a).

Using quantitative and qualitative analyses, Hutnik and Gregory (2007) evaluated cultural sensitivity training of 350 nursing students in the United Kingdom. In responses to an immediate post-training questionnaire trainees gave a mean rating of 3.9 (on a scale of 1 *the least* to 5 *the most*) for the usefulness and clarity of the workshop (duration not reported). Interpretative Phenomenological Analysis of semi-structured follow-up interviews with 11 representative trainees, 8 - 20 weeks following training, showed that trainees felt the workshop provided a safe space to talk; increased their cultural self-awareness and confidence in inquiring about cultural issues; and noted the importance of cultural sensitivity on professional work with patients (Hutnik & Gregory,

<sup>3</sup> Between 20% - 80% of staff in nine CATTs were trained

2007). Respondents also commented on workshop limitations and suggested improvements.

Bhui et al. (2007), in a review of evaluated models of professional education for cultural competency, commented on the limited evidence for the effectiveness of cultural competence training in mental health settings. Only nine studies were identified that met criteria for implementing a model of cultural competence and evaluating its effectiveness. Studies providing quantitative outcomes, showed that 30% of training participants expressed an “intention to modify practice” and 20% showed changes in behaviour following training (Bhui et al., 2007). Evaluation of a cultural consultation service found that 86% of practitioners were satisfied with the service, and better treatment, communication, empathy and understanding were reported (Bhui et al., 2007; Kirmayer, Groleau, Guzder, Blake & Jarvis, 2003). Cultural competence was seen as needing to be embedded at an organisational level. Evaluation of organisational approaches showed that more culturally competent organisations had “a pro-agency attitude among staff, openness and flexibility of provision, consistent pro-active and supportive supervision, and team based functioning and decision making” (Bhui et al., 2007, p. 7).

The studies reviewed suggest that cross-cultural training is generally well-received, valued and perceived by participants to be beneficial to their work with CaLD clients. However, the studies also highlight that measures of transfer to practice and organisational implementation are either lacking, or vary in their nature (e.g., case reports, involuntary admission rates, video-taped role-plays, minority client attrition), and provide different outcomes, perhaps due their lack of comparability. As remarked by Bhui et al. (2007) “organisational performance frameworks to assess impacts are under developed” (p.8). Betancourt, Green, Carrillo, & Ananeh-Firempong (2003) point out that the focus in improving and evaluating cultural competence has been on the clinician-client interaction, but a greater focus is required on the multiple levels of the health care system.

## **Aims of the evaluation**

The aims of the present evaluation study were to investigate whether mental health professionals showed increased cultural competence and service responsiveness on a number of summative pre- and post training quantitative and qualitative measures following training. In addition the study sought to determine the usefulness of the content, and the effectiveness of the training approach through post-training feedback measures. A short-term impact evaluation further aimed to establish whether a transfer of training occurred to mental health practice and organisational responsiveness.

# Method

## Ethics approval

The evaluation project was approved as a quality assurance activity by the St Vincent's Hospital (Melbourne) Research Governance Unit.

## Course participants

A total of 92 professionals from clinical AMHSs, PDRSSs and other community organisations in Victoria attended the CCMHSP course, of whom 33 (35.9%) completed all six modules. Registration priority was given to staff members from two AMHSs participating in the pilot project to improve service responsiveness to CaLD clients and carers, and to Cultural Portfolio Holders from other AMHSs and PDRSSs. Other participants registered in response to website and email promotion of the course. Table 1 provides the background details of 74 participants who completed the course registration form. Discrepancies in numbers are because some participants who attended did not register for the course, while others did not complete all details on the registration form. The number of participants who completed each evaluation measure is reported in the relevant sections below.

Participants represented Child and Adolescent, Youth, Adult, and Aged Persons' MHSs, as well as PDRSSs and other community services, with the largest groups working in adult clinical MHSs (39.2%) and in PDRSSs (24.3%, Table 1). The full range of mental health (and other) professional backgrounds were represented, with the largest group comprising nurse/psychiatric nurses (28.4%) followed by social workers (21.6%). A Cultural Portfolio Holder role was held by 32.4% of participants. Participants had between 1 and 10 or more years' experience in mental health or related services, with an even distribution of experience; 20% had had no previous cross-cultural training, 20% were CaLD-born, 37% reported having at least one CaLD parent, and 37% spoke a language other than English (LOTE), but only 10% reported being able to communicate clinical information in a LOTE.

## Instruments

Summative pre- and post-training measures included a 6-item Cross-Cultural Confidence in Mental Health Practice and Organisational Responsiveness (CCMHP) measure with 5-point Likert-type response scales (Appendix A), and a CaLD Case Study (Appendix B), requiring qualitative responses regarding cultural factors that might influence client presentation, assessment and treatment. Formative evaluation measures included Post-Training Feedback Forms (Appendix C) and reflective feedback sessions, each obtained immediately after every module (Appendix D shows the question format guiding the reflective feedback sessions). Longer-term impact follow-up interviews were conducted by telephone one month following training completion (Appendix E). Further details of the instruments are provided in the following sections. Findings from the pre- and post-training measures are reported first, followed by the post-training feedback measures and then the follow-up interviews.

**Table 1. Background characteristics of CCMHSP course participants**

Characteristic	No.	%
<b>Training site</b>		
Goulburn Valley	25	29.4
VTPU	32	37.6
Werribee Mercy	13	15.3
VTPU & Werribee Mercy	15	17.6
Total	85	100.0
<b>Type of service</b>		
CAMHS	2	2.7
Youth MHS6	6	8.1
Adult MHS	29	39.2
Aged Persons MHS	1	1.4
Across CAMHS, Adult and/or Aged	7	9.5
PDRSS	18	24.3
Migrant /other service	5	6.8
Sub-total	68	91.9
Missing data	6	8.1
Total	74	100.0
<b>Profession</b>		
Nurse/Psychiatric Nurse	21	28.4
Social Worker	16	21.6
PDRSS/Community development/Outreach worker	10	6.8
Consumer/Carer Consultant, Teacher, Personal Care, Migrant Service role	9	6.8
Psychologist/Counsellor	5	5.4
Occupational Therapist	3	4.1
Psychiatrist/Psychiatry Registrar	1	1.4
Sub-total	65	87.8
Missing data	9	12.2
Total	74	100.0
<b>Years in mental health/related service</b>		
1-3 years	17	23.0
3-5 years	10	13.5
5-8 years	13	17.6
8-10 years	2	2.7
10+ years	17	23.0
Sub-total	59	79.7
Missing data	15	20.3
Total	74	100.0
<b>Cross-cultural training in last 3 years</b>		
None	15	20.3
1-3 hours	15	20.3
1-2 days	13	17.6
3-5 days	8	10.8
5+ days in sessions	5	6.8
5+ days in course	2	2.7
Sub-total	58	78.4
Missing data	16	21.6
Total	74	100.0



**Table 1. Background characteristics of CCMHSP course participants (cont'd)**

Characteristic	No.	%
<b>Previous cross-cultural training was delivered by:</b>		
N/A no previous training	19	25.7
VTPU	20	27.0
Foundation House	3	4.1
VTPU & Foundation House	11	14.9
Other: MRC, Jewish care, MHS	3	4.1
Sub-total	56	75.7
Missing data	18	24.3
Total	74	100.0
<b>Participant's birthplace</b>		
Not CaLD	45	60.8
CaLD-born	14	18.9
Sub-total	59	79.7
Missing data	15	20.3
Total	74	100.0
<b>Participant's parents' birthplace</b>		
No parents CaLD-born	32	43.2
At least 1 parent CaLD-born	27	36.5
Sub-total	59	79.7
Missing data	15	20.3
Total	74	100.0
<b>Ability to speak a language other than English (LOTE)</b>		
Does not speak a LOTE	32	43.2
Speaks a LOTE	27	36.5
Sub-total	59	79.7
Missing data	15	20.3
Total	74	100.0
<b>Ability to communicate mental health information in LOTE</b>		
Not applicable	34	45.9
Not at all difficult	7	9.5
Slightly difficult	10	13.5
Quite difficult	4	5.4
Very difficult	4	5.4
Sub-total	59	79.7
Missing data	15	20.3
Total	74	100.0
<b>Number of modules attended</b>		
One module	4	5.4
Two modules	5	6.8
Three modules	1	1.4
Four modules	6	8.1
Five modules	19	25.7
Six modules	33	44.6
Sub-total	68	91.9
Missing data	6	8.1
Total	74	100.0
<b>CPH Role</b>		
Has CPH role	24	32.4
Not a CPH	49	66.2
Missing data	1	1.4
Total	74	100.0

# Findings from the Cross-Cultural Confidence in Mental Health Practice and Service Responsiveness (CCMHP) Measure

The CCMHP (Appendix A) was administered immediately before the first module of the course, and at the end of Module 5. It was expected that there would be a significant post-training improvement in participants' scores on the CCMHP.

## Participants

A total of 36 participants completed both pre- and post-course CCMHPs, 23 completed pre-course CCMHPs only, and 15 completed post-course CCMHPs only.

## The Instrument

The six items of the CCMHP were designed by the VTPU to obtain participants' ratings of their own confidence in cross-cultural mental health practice, their knowledge, skills and awareness of practice with CaLD clients, and their evaluation of their service's cultural responsiveness. Ratings were on 5-point Likert-type scales.

## CCMHP Scale Analysis

To reduce the data, principal components analysis with Oblimin rotation of the six items of the CCMHP showed that the first two factors had eigenvalues exceeding 1 (1.98 and 1.30, respectively) and explained 54.7% of the variance. Items loading on factor 1 (and factor loadings) included 3 *Own knowledge and skills*<sup>4</sup> (.87) and 1 *Confidence* (.76), and was named Cultural Competence. Items loading on factor 2 included 5 *Service responsive* (.68), 2 *Knowledge and skills needed* (.66), 4 *Influence of culture on practice* (.50), and 6 *Barriers to responsiveness* (.47), and was named Cultural Practice. Factors were not significantly correlated,  $r = .08$ , indicating they were independent. Reliability analysis yielded Cronbach's alpha coefficients of .74 for the Cultural Competence sub-scale, .41 for the Cultural Practice sub-scale and .53 for the CCMHP total scale. The low to moderate alphas indicate that the scales were adequately internally consistent.

## Pre- and Post-Course Findings

Pre- and post-training means for all items and sub-scales are shown in Table 2 and for the sub-scales in Figure 1. *T*-tests for independent samples (suitable for unequal samples) showed that there was a significant increase in the mean Cultural Competence sub-scale and total CCMHP scores, while there was an increase approaching significance in the mean Cultural Practice sub-scale score. This suggests that the CCMHSP course contributed to trainees' increased sense of cultural competence following training. While the course influenced participants' perceptions that there had been improvements in their own cultural practice and in their understanding of the need for cultural responsiveness at the organisational level, these changes were less marked.

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<sup>4</sup> See appendix for full wording of items.

**Table 2. Pre- and post-training means for CCMHP items and sub-scales**

Items <sup>1</sup>	Pre-training (n=58)	Post-training (n=50)	t(df)	p =
	Means(SD)	Means(SD)		
1. Your confidence about cross-cultural MH practice	2.66(1.07)	3.72(0.83)	5.81(105)	
2. Difference in knowledge/skills needed for CaLD compared with Australian-born clients	4.62(0.67)	4.54(0.81)	0.56(95)	
3. Self-rating of knowledge/skills with CaLD compared with Australian-born clients	1.83(1.14)	2.78(1.31)	3.99(98)	
4. Awareness of client's CaLD background influences my mental health practice	3.66(1.04)	4.24(1.06)	2.89(103)	
5. Responsiveness of your MHS to CaLD clients and carers	3.40(0.99)	3.52(0.91)	0.68(106)	
6. No barriers to culturally sensitive practice in my workplace	2.81(1.16)	2.96(1.26)	0.64(101)	
Mean Cultural Competence <sup>2</sup>	2.24(0.98)	3.25(0.80)	6.67(106)	.000
Mean Cultural Practice <sup>3</sup>	3.62(0.59)	3.82(0.56)	1.76(106)	.08 <sup>4</sup>
Total CCMHP scale	3.16(0.56)	3.63(0.47)	4.65(106)	.000

<sup>1</sup> Response range to items as numbered above: 1. *1 Not confident - 5 Very confident*; 2. *1 Very much the same - 5 Very different* (this item has been re-coded in the opposite direction to that in the measure); 3. *1 Not as good - 5 Much better*; 4. *1 Not at all - 5 A lot*; 5. *1 Not at all responsive - 5 Very responsive*; 6. *1 Totally disagree - 5 Totally agree*. <sup>2</sup> Mean of items 1 and 3. <sup>3</sup> Mean of items 2, 4, 5 and 6. <sup>4</sup> Not significant.

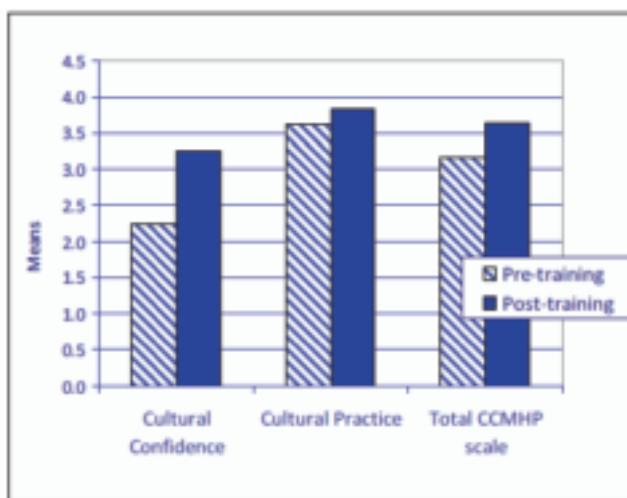


Figure 1. Pre- and post training mean scores on sub-and total scales of the CCMHP

### Participant Background Factors and CCMHP Scores

To investigate whether participants' employment and cultural background were associated with changes in mean scores on the CCMHP, univariate analyses of variance (ANOVAs) were conducted, with Mean Cultural Competence and mean Cultural Practice as dependent variables, and training stage and background factors as independent variables. Categories of background factors were collapsed to provide sufficient numbers in cells and included cultural portfolio holder role, professional background, type of mental health service, years in mental health (or other) service, amount of previous cross-cultural training, and CaLD background. None of these factors were significantly associated with changes in CCMHP sub-scale and total scale scores following training. These findings suggest that the benefits of the training CCMHSP course occurred regardless of the participants' work experience and background.

# Findings from Cross-Cultural Case Study Responses

Immediately before Module 1 and immediately following Module 5, trainees were asked to write brief open-ended responses to the Case Study of Ahmed (shown in Appendix B), nominating cultural factors that needed to be considered when assessing and treating a CaLD client. The aim was to evaluate the extent to which participants might be able to apply cross-cultural learning in practice with CaLD clients. It was expected that, post-training, there would be:

- a significant increase in the number of cultural factors identified as potentially relevant; and
- a shift in response content from the cultural and linguistic background of the client to responses that focused on migration and settlement issues, and cultural factors that might influence clinical presentation.

## The Measure

The case study was developed by compiling de-identified features of cross-cultural cases encountered by, or reported to VTPU staff. The case study was designed to incorporate cultural factors that were addressed in each of the modules of the course. The VTPU identified 15 potential issues that could be nominated. Eleven lines were provided to write responses to encourage as many responses as possible on a single page, while the lines were dot-pointed to discourage overly long discursive responses.

## Pre- and Post-Course Quantitative Findings

Table 3 shows that the number of responses to the Case Study increased in range from 3 – 16 pre-training, to 3 – 27 post-training and the total number of responses from 525 to 731. As 60 participants completed the pre-training case study and 52 the post-training case study, a 2-tailed *t*-test for independent groups was used to test whether the mean number of responses changed following training. As predicted, the *t*-test showed that the mean number of responses increased significantly (Figure 2). These findings suggest that participants acquired increased awareness and knowledge regarding the range of cultural factors that might influence a CaLD case presentation following training, and the potential for increased skills in practice. For the purposes of this discussion these capacities will be named Cross-Cultural Case Competence (CCC).

**Table 3. Frequencies and mean number of pre- and post-training responses to the Case Study**

	Pre-training	Post-training
No. participants	60	52
No. responses	525	731
Mean no. responses( <i>SD</i> )	8.75 (3.12)	13.77 (4.45) <sup>1</sup>
Range of responses	3 - 16	3 - 27

<sup>1</sup>  $t(111) = 7.01, p < .000$

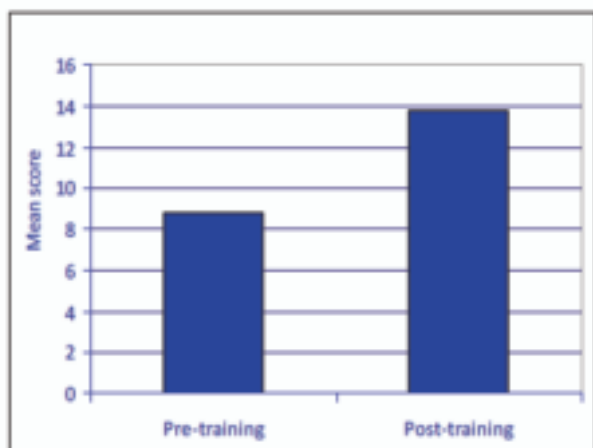


Figure 2. Mean number of responses to Case Study pre- ( $n=60$ ) and post-training ( $n=52$ )

### *Factors Associated with Cross-Cultural Case Competence*

To determine whether any participant background factors were associated with changes in mean CCC scores univariate ANOVAs were conducted with training stage and background factors as independent, and CCC scores as dependent variables. As for the CCMHP scale, categories were collapsed for some background factors to ensure adequate cell numbers. The ANOVAs showed that there were no significant changes in mean CCC scores associated with trainees' experience or background.

Pearson correlations were conducted to investigate whether there were any associations between the mean pre- and post-training CCC scores and the mean scores on the Cultural Competence and Cultural Practice sub-scales and total CCMHP. No significant correlations were found, which indicates that the participants' self-ratings of Cultural Competence and Cultural Practice were unrelated to the number of responses they made to the Case Study. This may in part be due to the limitations of taking a quantitative approach to analysing the Case Study responses.

### **Pre- and Post-Course Qualitative Findings**

In a qualitative approach, Case Study responses were inspected for emerging themes and after a number of iterations were coded into 36 response themes. These themes were consistent with the 15 themes initially identified by VTPU, but required sub-classification to incorporate more detailed responses.

MultResponse in SPSS Version 16 was used to determine the frequency of the themes pre- and post-training. Appendix F shows the 36 themes and response frequencies. To facilitate further analysis the 36 themes were grouped into nine superordinate or major themes, also shown in Appendix F and summarised in Table 4. Figure 3 shows the themes sorted in order of pre-training frequency. The most frequently mentioned

response themes both pre- and post training related to *Post-migration, refugee and settlement experiences*, followed pre-training by *Differentiate idioms of distress & beliefs from mental illness*, but post-training the second most frequent response was *Pre-migration and refugee experiences*.

**Table 4. Major themes emerging from Case Study responses and frequencies for pre- ( $n = 60$ ) and post-training ( $n = 53$ ) participants**

Themes	Pre-training		Post-training		Total	
	No. themes	%	No. themes	%	No. themes	%
1. Cultural, linguistic background	87	16.6	74	10.1	161	12.8
2. Pre-migration/refugee experiences	62	11.8	103	14.1	165	13.1
3. Post-migration/flight, settlement experiences	136	25.9	228	31.2	364	29.0
4. Mental health worker/client relationship; cultural consultation	32	6.1	21	2.9	53	4.2
5. Idioms of distress, beliefs, differentiate from mental illness	87	16.6	99	13.5	186	14.8
6. Explanatory models; negotiating treatment	40	7.6	63	8.6	103	8.2
7. Differentiating delusions	33	6.3	40	5.5	73	5.8
8. Risk assessment; protective cultural factors	15	2.9	40	5.5	55	4.4
9. Standard assessment	33	6.3	63	8.6	96	7.6
Total responses	525	100.0	731	100.0	1,256	100.0

$\chi^2(df = 8) = 31.44, p < .0001$

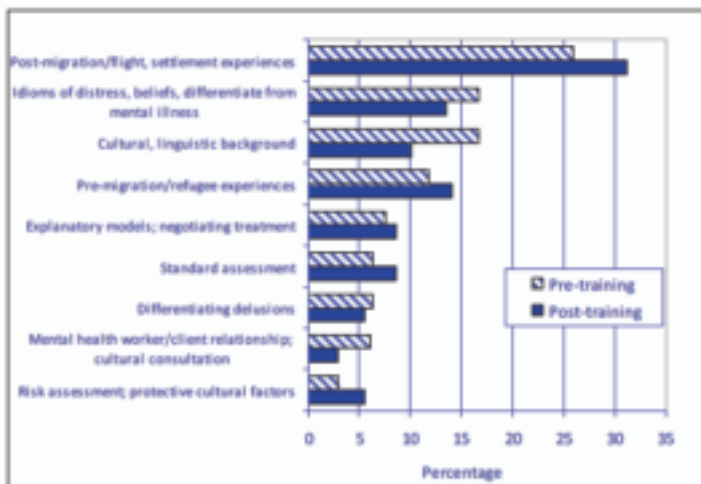


Figure 3. Change in response themes to Case Study pre- ( $n = 525$ ) and post-training ( $n = 731$ ), sorted in order of pre-training response frequency

To test whether significant changes occurred in the focus of responses following training, a chi-square test was conducted on the tabulated data (Preacher, K. J., 2001, April). This showed a significant difference in the distribution of the responses from pre- to post-training. Inspection of Figure 3 and Table 4 shows that, as predicted, there was a decrease in the percentage of responses relating to the client's *Cultural and linguistic background* from 16.6% to 10.1%. It appears that the focus of responses shifted primarily to the theme, *Post-migration, refugee and settlement experiences* of the client, which was the most frequent response both pre- and post-training, but the percentage of responses increased from 25.9% to 31.2%. There was also a shift in post-training responses to *Pre-migration and refugee experiences*, which increased from 11.8% to 14.1%. Contrary to expectations, there were no marked increases in the percentage of the more clinically-oriented response themes, such as *Differentiate idioms of distress & beliefs from mental illness*.

However, a number of participants already had a well-developed understanding of the cultural factors that might influence case presentation before training, but extended the range of cultural factors to be considered following training. One participant's responses, shown in Table 5, illustrate this pattern, with only three pre-training responses, but one of which recognises the need to investigate cultural beliefs and to differentiate these from possible mental illness symptoms. Following training the participant's number of responses increased to 13, and addressed a greater range of potential issues.

**Table 5. An example of participants' pre- and post-training responses**

Pre-training	Post-training
<ul style="list-style-type: none"> <li>• May have cultural beliefs [19]<sup>1</sup> relating to the argument with his neighbour– more info on "evil influence" and background to this [20]</li> <li>• Ahmed's understanding of mental health services based on his culture [31]</li> <li>• History of migration [7]</li> </ul>	<ul style="list-style-type: none"> <li>• Explore mental state – presentation of somatic symptoms may be Ahmed's way of expressing his distress [18]</li> <li>• Factors to consider would be migration history [7] / settlement history [8]</li> <li>• Insight into Ahmed's world his cultural beliefs and norms [19]</li> <li>• Developmental history [29]</li> <li>• Family support network [9]</li> <li>• His beliefs around suicide [27] – risk &amp; protective real factors [28]</li> <li>• Explore possibility of being discriminated against [25]</li> <li>• Forensic history [29]</li> <li>• Attitude towards seeking help and support [29]</li> <li>• Current psycho-social stressors [11]</li> <li>• Religious beliefs [19]</li> <li>• Why was he aggressive towards GP? [29]</li> <li>• His understanding of what was happening to him [32]</li> </ul>

<sup>1</sup> Bracketed numbers represent codes assigned (see Appendix F)



Further examples of pre- and post-training responses classified under the major themes are shown in Table 6. These responses further indicate that some participants were already aware of relevant cultural factors at the commencement of training. However, as shown above, the number of participants demonstrating this understanding has been shown to increase following participation in the CCMHSP course. In addition, some respondents showed greater depth and detail regarding the issues to be considered following training.

**Table 6. Examples of responses for each major Case Study theme pre- and post training**

Pre-training	Post-training
<b>1. Cultural, linguistic background</b> <ul style="list-style-type: none"> <li>Country he came from (48)<sup>1</sup></li> <li>Interpreting services for understanding meaning of language (16)</li> </ul>	<ul style="list-style-type: none"> <li>Nationality, English language skills (17)</li> <li>Level and adequacy of communication. Interpreter required (58)</li> </ul>
<b>2. Pre-migration/refugee experiences</b> <ul style="list-style-type: none"> <li>History of migration (2)</li> <li>Past trauma, i.e., torture, war etc. (18)</li> </ul>	<ul style="list-style-type: none"> <li>What was the nature of his migration experience? (67)</li> <li>Why had he to leave? Immigration hx. Trauma / was he in camps or experienced conflict? (25)</li> </ul>
<b>3. Post-migration/flight, settlement experiences, current situation</b> <ul style="list-style-type: none"> <li>What have been the challenges on migrating? (38)</li> <li>Family supports, does he have any? (1)</li> <li>What assistance he was receiving, e.g., English classes, benefits, housing, with purchasing food, clothing, etc? (11)</li> <li>Degree of acculturation – identity? (56)</li> </ul>	<ul style="list-style-type: none"> <li>Migration and settlement history would help exploring these symptoms to a certain level (9)</li> <li>Questions about family in this country or not? Recent losses, deaths? (53)</li> <li>Support systems, ... does he belong to community? (25)</li> <li>Consider values, e.g., collectivist? Impact of values on help-seeking re mental illness (38)</li> </ul>
<b>4. Mental health workers' awareness/client relationship; cultural consultation</b> <ul style="list-style-type: none"> <li>Gender of clinicians may need to be considered (39)</li> <li>Would a female interpreter be culturally appropriate? (75)</li> <li>Information from family regarding symptoms they have observed and specific cultural issues to be considered, recent stressors (43)</li> </ul>	<ul style="list-style-type: none"> <li>Insight on mental illness, and clinician respect and sensitivity (33)</li> <li>Need to consider time needed to build trust in working with him (45)</li> <li>Consult cultural interpreter, family, community leader to help (49)</li> </ul>
<b>5. Clinical assessment: differentiate idioms of distress &amp; beliefs from mental illness</b> <ul style="list-style-type: none"> <li>Somatisation as a way of expressing distress (29)</li> <li>Religious beliefs, superstitious beliefs (21)</li> <li>May have cultural beliefs relating to the argument with his neighbour – more info on "evil influence" and background to this (2)</li> </ul>	<ul style="list-style-type: none"> <li>Explain physical presentation – what do they mean in his culture? (48)</li> <li>Is there a cultural belief in hexes, 'evil eye' etc? (67)</li> <li>Cultural beliefs around neighbour, people in the street, figure of man in his room? (37)</li> </ul>
<b>6. Clinical assessment: investigate explanatory models; negotiating treatment</b> <ul style="list-style-type: none"> <li>Important to ask him what he believes is happening for/to him and what he believes he needs to help him (59)</li> <li>Own beliefs (or cultural beliefs) re mental illness? (23)</li> </ul>	<ul style="list-style-type: none"> <li>How would this behaviour be viewed before Australia? How would it be seen/treated/ overcome? (73)</li> <li>Negotiating skills – compromise – parallel models of intervention. Ahmed allowed to apply his beliefs and clinicians apply their skills, both work together to get positive outcomes (33)</li> </ul>
<b>7. Clinical assessment: differentiate delusions from valid experiences</b> <ul style="list-style-type: none"> <li>Experiences of discrimination (47)</li> <li>Country of origin's state of war/peace (i.e. PTSD stuff) (31)</li> </ul>	<ul style="list-style-type: none"> <li>Why feelings of discrimination? Is this related to past treatment in country of origin? (48)</li> <li>Legal status – is he fleeing from a stranger? Are there spies? Clarify this, is it real or imagined? (11)</li> </ul>
<b>8. Risk assessment; protective cultural factors</b> <ul style="list-style-type: none"> <li>Address what suicidal thoughts and suicide mean in his culture and in Australia (41)</li> <li>May have shame re suicidal ideation (28)</li> </ul>	<ul style="list-style-type: none"> <li>Has he spoken to a clergy member about his feelings of suicide – is this acceptable? (70)</li> <li>Identify protective factors – family, religion, to assess risk (43)</li> </ul>
<b>9. Standard clinical assessment, diagnosis (no reference to culture)</b> <ul style="list-style-type: none"> <li>Is there a family hx of odd behaviour/mental illness/suicide (59)</li> <li>Assessment for psychosis (24)</li> </ul>	<ul style="list-style-type: none"> <li>Does he have a psychiatric history if so what sort (violent, abusive, etc.) (66)</li> <li>Ahmed sounds to be suffering from paranoia and may need to be further engaged by the CATT team and medical profession (72)</li> </ul>

<sup>1</sup> Numbers in parentheses represent case numbers assigned for purposes of data coding and entry, not for participant identification

## Findings from the Post-training Feedback Form and Reflective Learning Comments

To obtain information on the effectiveness of the content and training approach of the CCMHSP course, the Post-Training Feedback Form (PTFF) was administered to trainees immediately following each module. In addition, reflective learning discussions were led by trainers after each module to encourage participants to reflect on how the learning from the module might be applied in daily mental health practice.

### Participants

The number of participants completing PTFF Forms for each module is shown in Table 7.

### Instruments

The PTFF, (Appendix C) asked participants to rate each session in the module on the content, the use of case studies, activities used, and handouts and resources, on a 5-point Likert-type scale from 1 *Not relevant/useful* to 5 *Very relevant/useful*. Qualitative comments were also sought regarding which aspect of the session was most useful or interesting, what changes were suggested to improve the session, and any other comments.

Questions guiding the reflective learning session (Appendix D) asked participants how the module would influence their practice and view of CaLD clients; what barriers they might encounter in implementation and how they might overcome these barriers; did the course content cover areas of need and was the training approach appropriate; and how could the learning be disseminated in the participant's service? One trainer led the discussion while the other recorded responses.

### Results for the PTFF

#### *Mean Relevance/Usefulness Ratings*

Mean ratings are shown in Table 7 for the content, case studies, activities, and handouts/resources, for the sessions comprising each module. All sessions were rated well in excess of a mean of 4.0 on relevance/usefulness, with overall session means showing a range of 4.5, for Service Development Strategies in Module 6, to 4.8 for Cultural Beliefs & Explanatory Models in Module 4. The various aspects of the sessions were similarly highly rated, with a mean rating range of 4.3 for activities in the Communication with CaLD Consumers and Carers session in Module 3, to 4.9 for the content of both sessions in Module 4, Understanding Beliefs & Explanatory Models. Overall Course ratings, completed at the end of Module 6, were consistently high across all aspects of the course, with an overall mean of 4.7 (Table 7 and Figure 4).

#### *Qualitative Post-Training Feedback*

A thematic analysis was conducted of the qualitative responses on the PTFF for each session. Limitations of space prevent presenting the full range of comments, but

Table 8 shows the most frequent theme mentioned as useful or interesting in each session, and the most frequently mentioned suggestions for change to improve a session.

### *Usefulness of sessions*

The use of case studies was rated as useful or interesting (abbreviated hereafter to "useful") by one quarter of participants in the first session of Module 1, Mental Health, Acculturation and Identity. Although not the most frequently mentioned in other sessions,

**Table 7. Mean scores on ratings of *relevance/usefulness* of module sessions<sup>1</sup>**

Modules & sessions	N	Content M(SD)	Cases M(SD)	Activities M(SD)	Handouts M(SD)	Total M(SD)
1. Migration, acculturation and identity: Influences on mental illness						
a. Mental health, acculturation, identity	57	4.7(0.44)	4.8(0.50)	4.6(0.63)	4.8(0.37)	4.7(0.38)
b. Mental health, migration & refugee status	54	4.7(0.62)	4.7(0.60)	4.7(0.58)	4.8(0.47)	4.7(0.52)
Module 1 Total Mean	57	4.7(0.53)	4.7(0.55)	4.6(0.61)	4.8(0.42)	4.7(0.40)
2. Values, the sense of self and emotions across cultures						
a. Cultural values and the sense of self	47	4.8(0.42)	4.5(0.68)	4.4(0.71)	4.8(0.47)	4.6(0.46)
b. Understanding emotion across cultures	49	4.7(0.61)	4.5(0.79)	4.4(0.89)	4.8(0.48)	4.6(0.52)
Module 2 Total Mean	49	4.7(0.52)	4.5(0.74)	4.4(0.80)	4.8(0.48)	4.6(0.46)
3. Communicating effectively across cultures						
a. Working effectively with interpreters	45	4.7(0.62)	4.5(0.76)	4.6(0.66)	4.8(0.39)	4.7(0.51)
b. Communication with CaLD consumers and carers	44	4.7(0.62)	4.6(0.65)	4.3(0.89)	4.6(0.69)	4.6(0.63)
Module 3 Total Mean	43	4.7(0.62)	4.6(0.71)	4.4(0.78)	4.7(0.54)	4.6(0.52)
4. Understanding beliefs & explanatory models						
a. Cultural beliefs & explanatory models	52	4.9(0.42)	4.8(0.51)	4.7(0.51)	4.8(0.47)	4.8(0.38)
b. Integration into mental health practice	50	4.9(0.35)	4.8(0.45)	4.6(0.61)	4.6(0.56)	4.7(0.38)
Module 4 Total Mean	50	4.9(0.39)	4.8(0.48)	4.6(0.56)	4.7(0.52)	4.7(0.36)
5. Cross-cultural risk assessment and cultural formulation <sup>2</sup>	53	4.7(0.68)	4.7(0.50)	4.5(0.58)	4.7(0.52)	4.6(0.47)
6. Working within organisations to improve CaLD responsiveness						
a. Service development strategies	39	4.5(0.79)	4.4(0.75)	4.4(0.79)	4.5(0.68)	4.5(0.69)
b. Community development initiatives	35	4.5(0.66)	4.5(0.70)	4.6(0.61)	4.7(0.64)	4.6(0.61)
Module 6 Total Mean	35	4.5(0.73)	4.5(0.73)	4.5(0.70)	4.6(0.65)	4.5(0.61)
THE COURSE OVERALL	35	4.8(0.39)	4.7(0.46)	4.6(0.60)	4.7(0.54)	4.7(0.38)

<sup>1</sup> Ratings were on a scale of 1 *Not relevant/useful* to 5 *Very relevant/useful*.

<sup>2</sup> Module 5 was evaluated as a single session.

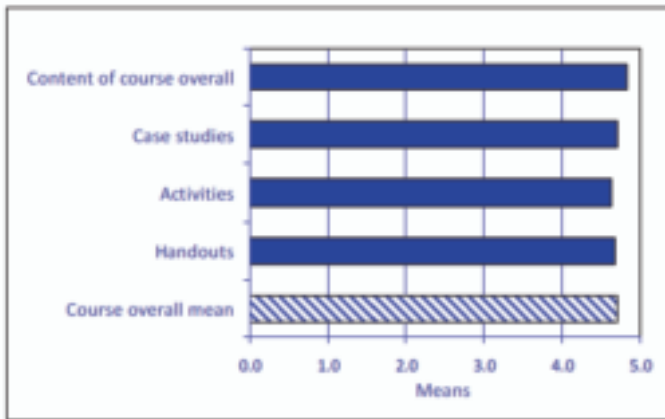


Figure 4. Mean post-training feedback scores for Course Overall ( $N = 35$ )

**Table 8. Most frequently mentioned themes relating to what was most useful or interesting in sessions and changes suggested to improve sessions**

Modules and sessions	Most useful or interesting / Other comments	N (%) <sup>1</sup>	Changes suggested <sup>2</sup>	N (%)
<b>1. Migration, acculturation and identity: Influences on mental illness</b>				
a. Mental health, acculturation and identity	- Case studies	22 (24.2)	- More interaction, smaller groups, use of video	10 (16.1)
b. Mental health, migration and refugee status	- Photos, DVD; emotional, thought-provoking	19 (20.7)	- More on strategies, practice issues	17 (18.5)
Module 1: Other comments	- Interesting, worthwhile day enjoyed Module 1	22 (31.4)		
<b>2. Values, self and emotions</b>				
a. Cultural values, sense of self & emotion	- Activity reflecting on/sharing values	17 (22.1)	- Vary presentation style - more visual aids, etc	8 (15.1)
b. Emotion across cultures	- Presentation framework/ all of session	14 (22.6)	- Vary structure: too rushed, more activities, more cultures	11 (21.6)
Module 2: Other comments	- Great, interesting day; thank you	12 (20.3)		
<b>3. Communicating effectively across cultures</b>				
a. Working effectively with interpreters	- Role play; demonstrated complexity	17 (25.4)	- Structure: more inter-activities, with vignettes	5 (10.4)
b. Communication with CaLD consumers and carers	- Carer and consumer presentation/perspectives	24 (31.6)	- Too much information, not enough time	9 (19.6)
Module 3: Other comments	- Very useful day, informative	17 (35.4)		
<b>4. Understanding beliefs &amp; explanatory models</b>				
a. Cultural beliefs and explanatory models	- Cultural illness beliefs; in relation to mental illness	21 (25.6)	- More group discussion, activities	7 (12.5)
b. Integration into mental health practice	- Use of video/DVD: shows explanatory model in practice	22 (27.5)	- Participant role play needs more client information or own-client role	8 (14.8)
Module 4: Other comments	- Very well presented; good duration, balance; best day; enjoying the training; thanks	23 (36.5)		
<b>5. Cross-cultural risk assessment and cultural formulation<sup>3</sup></b>				
	- Influence of culture in risk assessment; cultural risk and protective factors	18 (23.7)	- Structure: keep Dan case, (23.7) together; put up group formulation; provide case notes; some slides too crowded; more/less interaction	7 (12.1)
<b>6. Working within organisations to improve CaLD responsiveness</b>				
a. Service development strategies	- Group discussion, sharing ideas re service development, organisational issues, service barriers	15 (30.0)	- More interaction, activities	4 (10.0)
b. Community development	- Somali Mental Health Project - demonstrates working with CaLD clients	12 (21.1)	- More time for group discussion	5 (12.5)
Module 6: Other comments	- Very good, inspirational session	8 (20.5)		
<b>THE COURSE OVERALL</b>				
	- All 6 modules really useful, balanced; enjoyable; well-presented; resource packs	13 (20.3)	- Structure: require CaLD service audit for Module 6; more flexibility in activities; more visual aids	5 (12.2)
COURSE OVERALL Other comments	- Good, relevant course, thank you	8 (20.0)		

<sup>1</sup>Percentage of respondents completing PTFF (detail shown in Table 7). <sup>2</sup> Only comments recommending specific changes are shown here. The percentage of respondents making no comment, or commenting that no changes were needed ranged from 51.5%, for Module 5 to 81.3% for Working effectively with interpreters. <sup>3</sup> Module 5 was evaluated as a single session.

the benefit of case studies was mentioned by 10% - 17% of participants in both sessions of Modules 1, 2, 4 and 5 (case studies as such were not used in Modules 3 and 6). Participants commented that case studies helped to clarify theories put forward, and provided a link to practice. Visual aids such as photos and DVDs were found to be very powerful and thought-provoking in Module 1, Session B, Mental Health, Migration and Refugee Status, conducted by Foundation House. The use of a DVD was also seen as useful in Session B of Module 4, Integration into Mental Health Practice, where this visual aid was seen as demonstrating how to negotiate explanatory models in practice. Interactive exercises were perceived as useful by 22.1% of participants in Session A of Module 2, Cultural Values, Sense of Self and Emotion, enabling them to reflect on and share their own values. Group discussions, interactive exercises and role plays were seen as useful by between 9% and 35% of participants in most sessions of Modules 1, 3, 4, 5, and 6. The role play in Module 3, Session A, Working Effectively with Interpreters, helped participants to experience the complexity of the interpreter's role and of the clinician's responsibilities.

The remaining most frequently-mentioned comments related to the content and framework of particular sessions, including Module 2B, 3B, 5 and 6B. For example, the *Presentation framework* of Session B, Module 2, Emotion across Cultures, was considered useful by 22.6% of respondents, while the *Somali Mental Health Project* was valued by 21.1% of participants in Module 6, Session B, Community Development Initiatives, as it *demonstrated working with CaLD clients*. Other comments made most frequently following each module generally praised the training day, e.g., Module 4 was described as *Very well presented; good duration, balance; best day; enjoying the training; thanks*. Similar sentiments were expressed in the Overall Course evaluation where the main theme relating to the usefulness of the course was, *All 6 modules really useful, balanced; enjoyable; well-presented; resource packs useful*, views expressed by 20.3% of participants. In *Other comments* on the course overall, 20% of trainees commented *Good, relevant course, thank you*.

### *Changes suggested*

As shown in Table 8, between 10% and 16.1% of participants recommended changes to most sessions requesting more interactive exercises (including group discussions) and use of visual aids. However, it should be noted that these views often contrasted with comments regarding the usefulness of a session: for example in Module 6 the most valued aspect of Session A, Service Development Strategies, was *Group discussion, sharing of ideas re service development, organisational issues, service barriers*, comments endorsed by 30% of participants, while 10% requested *More interaction, activities*. Some specific changes were suggested for Module 4b, Integration into Mental Health Practice, where it was suggested more information was needed to facilitate the role-play. For Module 5, Risk Assessment, various structural changes were recommended to improve the organisation of the module.

One other suggestion for change in relation to Modules 2B, 3B, and 6B, was that more time was needed for the session as there was too much information, or it was too rushed. Reflecting divided opinions on the issue of course duration, a small number of

participants in the Overall Course PTFF, suggested either that the course be condensed and shortened, delivered over a longer period, or delivered with shorter breaks between modules (there was generally a 1-month break between each module). It is important to note that, in the Overall Course PTFF, two-thirds of participants recommended either no change or recorded no comment when asked to suggest changes to improve the course. However, recommendations made provide useful feedback regarding areas for course improvement in terms of duration, activities and content.

## Results of Reflective Learning Feedback Sessions

Reflective discussion sessions held at the end of each module were transcribed and key themes were identified. These included Training Format, Cultural Competence, Service Development, and Collaboration and Community Development. These findings generally complement, reflect, and add depth to the PTFF findings.

### *Training format*

*Usefulness.* Across all modules, respondents commented on the usefulness of the training. In particular, the case studies, interactive activities, role plays and DVDs were perceived as valuable and useful in translating theory into practice. In relation to Module 3, Session B, Communication with CaLD Consumers and Carers, particular reference was made to the value of the contribution of guest speakers from different CaLD backgrounds and to participants' personal stories.

*Limitations.* Comments by participants on limitations of some of the modules included, for Module 1: *Very useful, but unable to process it all*, while others sought additional content and detail. Changes recommended to Module 2 included inviting other trainers, such as CaLD consumers, and also using other formats such as role plays and videos. In Module 3, Session A, participants expressed a need for more information on telephone interpreting, while in Session B of Module 3, a need for more time for discussion in was emphasised. The role play used in Module 4, Understanding Cultural Beliefs and Explanatory Models, was considered valuable, but it was suggested that it would be helpful to, *Maybe do one of the case studies that has been explored already in the presentation*, or to play the role of a client with whom the participant was familiar.

In relation to Module 5, Risk Assessment, a participant reflected on having learnt the dangers of stereotyping particular cultural groups. Some participants found the DVD on Suicide and Spirituality difficult to follow. In reviewing the CCMHSP course to this point some respondents commented on the difficulties of committing time for six modules, and suggested it would be good to condense them into two days. However, one respondent acknowledged, *I do not know what you would leave out of the training, as all the modules so far have been packed with relevant information*. Another agreed, saying that, *you wouldn't get that group discussion which is essential to digest the information by considering different viewpoints generated by different participants and facilitated by presenters*. Following Module 6, respondents suggested that involvement from other organisations would have been helpful to focus on models of collaboration between services, while others would have liked to hear more examples of



successful – and unsuccessful - models of practice in community development.

### *Cultural competence*

Many respondents remarked that the sessions had given them an enhanced understanding of issues for CaLD community members. This improved their sense of cultural competence and would benefit their work in the clinical setting, as well as contributing to an enriched discussion in clinical review meetings. In Module 3 specific reference was made to improvements in knowledge and skills in how to work appropriately with interpreters, and to the need to take into consideration the needs of carers.

In Module 4 participants commented that their cultural competence had been developed by understanding and applying the explanatory model framework. Some respondents noted that this framework was of use not only with patients from CaLD backgrounds but also to any individual. Hence the theme was identified that this training program may inform and enhance mental health care more generally. In this Module some participants commented that they would have liked to learn more about specific cultures. This suggests that for some the function of the explanatory model framework was not well understood, and the risks of stereotyping may be worthy of elaboration in future training.

Following Module 6 respondents recognised that that their cultural competence would be strengthened by undertaking action as a group, such as a CaLD Working Group, which would ... *mean we'll have more strength, to advocate and connect to local services.* It could also involve *making connections with ethnic communities using informal ways - it's not necessarily about approaching the topic of mental health straight away.*

### *Service Development*

In considering how to disseminate what participants had learned in the course, they identified scope for enhancing the cultural responsiveness of their service. For example, *At staff meetings we can work through a CaLD case and explore it together. This would allow staff who attended the training to provide information they have learned onto others.* Clinical presentation and review meetings, *team and organisational level meetings* were also perceived as forums for improving service delivery. Following Module 5, one respondent commented on the need to *review our documentation to get clinicians to take on CaLD issues, including some checkpoints within documentation.* *Need to assess spiritual and cultural context. Can't see how we can do any assessment without considering these issues.*

Respondents had also become aware of resources, including on-line resources, that they could access and distribute to colleagues. Inclusion of cultural issues into service policies, documentation and quality improvement activities was recommended as a further approach to service development. Cultural Portfolio Holders were seen as an important contact point for exchanging information.

Although some participants foresaw challenges in implementing best practice models (as were conveyed in the training) in the context of large case-loads, there was recognition that such work might lead to more effective service provision in the longer-term, including a reduced need for inpatient care.

With regard to Module 3, Session B, respondents pointed to the need to appoint more CaLD Consumer Advocates, particularly from African countries, if misunderstandings about mental health services by African communities were to be overcome. However, great demands are placed on Consumer Advocates, and ... *what they need [now] is the practical support to do this type of work in their respective communities. It is the responsibility of the Australian community to find a two-way process, as one or two African community leaders are not able to deal with the need within the African community.*

An overriding theme for improving service responsiveness was that more staff needed to be trained to improve cultural competence and for training resources to be more readily available. This was considered important in light of the possibility that the course may be “preaching to the converted”, where only interested individuals would attend. Importantly, respondents identified the need for follow-up to help participants to integrate and consolidate the benefits of the training, as *This education training requires time to digest - how does one apply the theory into practice?* To facilitate this process participants proposed providing further training and service development themselves: *We have been released in order to attend. It's important to show the value of this e.g., put together a staff in-service for others.* Another participant envisaged *Working towards a community forum.*

### *Collaboration and Community Development*

The Community Development session in Module 6, was perceived as helping participants to recognise the importance of establishing linkages, and collaborating with CaLD and other community agencies in the interests of optimal mental health care provision. *The mental health sector needs to reach out to the community sector so that the community sector can link with the mental health sector when needed in a crisis and as part of the ongoing care.* Another respondent commented, *Perhaps our service is also one of the jigsaw pieces so we need to share responsibility of care with other services.* Engaging with the Ethnic Services Council was seen as an opportunity for one participant to *think about what we can do on the acute unit.* It was recognised that it was necessary to *review systems within our services, to ensure that people coming to the service will continue to attend.*

### *Perceived Implementation Constraints on Participants*

A significant theme that emerged related to the constraints that participants perceived in their roles, particularly those working in clinical roles. While most clearly benefited from gaining an understanding of transcultural mental health assessment and treatment, systemic issues and reform processes, some respondents questioned their capacity to implement change. A number of participants spoke of the importance of service

leadership - from both senior clinicians and managers - in putting change into practice.

The VTPU, in partnership with managers and other key staff, has developed a range of service development strategies, including a secondary consultation program, to facilitate implementation of service change and to transfer learning from the CCMHSP course into mental health practice. The measures are to be supported by on-line resources.

## Findings from Follow-Up Interviews

To evaluate the short-term impact of the training program, follow-up telephone interviews were conducted 4 – 7 weeks following completion of the CCMHSP course by a member of the VTPU education and service development team. The overall aims of the interviews were to obtain participants' feedback on their experience of the course and its impact on their work and work environment, and to provide information to guide the development of future training programs.

### Participants

Twenty (60.6%) of the 33 participants who had completed all six modules were approached to participate in a 15-minute follow-up telephone interview. A total of 17 (51.5% of 33) participants were interviewed: one had resigned and could not be located, one had completed only five modules, and one did not respond to the interview invitation. The profession of the majority of respondents was nurse/psychiatric nurse ( $N = 7$ ), followed by social workers ( $N = 4$ ), and one each psychologist, research assistant, psychiatrist, carer consultant, consumer, and psychiatric services officer. The majority of participants worked in adult mental health services ( $N = 11$ ), while others worked in aged psychiatry ( $N = 2$ ), a combination of child and adolescent, youth, adult and aged mental health services ( $N = 2$ ), and youth mental health services ( $N = 1$ ). One participant did not record a response.

### Instrument

The interview schedule, developed by VTPU, is shown in Appendix E. The interview questions are reported in the Results section below.

### Results

The interviews were transcribed and feedback from each respondent was grouped according to the nine questions that were developed for this interview. Common and contrasting themes were identified and grouped. The following is a summary of the key themes, categorised according to each question. Some of the questions have been collapsed for the sake of brevity and illustrative comments are included.

1. *Has the training had an impact on how you work with CaLD clients? What [are] the most important outcomes of the course in regard to your work?*

Most respondents indicated that their work with CALD clients had been enhanced through the training. Many indicated that the impact was a general one, having gained a greater insight and understanding of issues faced by CaLD consumers. Some respondents identified specific outcomes such as an improved understanding of family dynamics affecting CaLD individuals, working effectively with interpreters, understanding the impact of trauma, and an understanding of CALD issues from the perspectives of carers.

*I am more aware of what to expect from a CaLD client... how to assess ...; even [the availability of the] 24 hr interpreter service which I never knew about and now I know. Probably how to assess clients from different cultural background, and to search more information about culture, their background... more information from them about the issues. In this way... it's more awareness.*

Several respondents noted that it might be too early to judge the impact one month following the completion of training. They suggested that impact might be more evident at a later stage as their awareness gradually increased, as they educated other clinicians and undertook further service development work. Three respondents indicated that the training had not made an impact on their work with CaLD clients, either because theirs was not a direct service role, or not many CaLD clients had attended their service.

2. *Has the training had an impact on your involvement in change within your service? What [are] the most important outcomes of the course in regard to your service?*

Most respondents indicated that the training had had a positive impact on their involvement within their service. The training had led to the development of cultural sensitivity within the service, dissemination of training resources and an increased understanding of cultural issues.

*It has. Last week I attended a meeting with VTPU and our senior management here... and we went away having decided that we would have a representative from each of the teams in the service to work on cultural issues... have a cultural champion really... so we could develop a more culturally sensitive service if you like... so yes.*

Additional specific outcomes that were identified included dissemination of training regarding working with interpreters and the growth of confidence in being able to advocate for the needs of CaLD individuals.

*Cultural perspectives have gained a higher profile in the way we work. We have recently received three referrals of CaLD young people and I made a special effort to alert the staff involved to the use of interpreters and possible problems which they may come across. I may not have been so forward before the course.*

Five respondents indicated that they were uncertain of the impact of the training at the level of the service or that it was too early to note any impact.

3. *Do you think anything about the course could be changed to improve outcomes in regard to your own work?*

Most respondents indicated that the course was comprehensive and did not suggest specific changes to improve their work.

*I was really happy with it. I don't think it really could be changed. It was done well.*

However, four respondents suggested that an abridged training program might allow a greater number of staff to attend.

*No, I think the course was fantastic... With the amount of people who were able to attend this course... it probably would be really good to have a short version of the course... really combined...*

On the other hand, two respondents would have preferred a more extensive training program with greater emphasis on case reports.

*I liked that the course was run over an extended period. It kept CaLD issues in one's mind for the duration. As a personal preference I would like more case studies, they make for a more memorable exercise.*

These comments highlight the need to provide learning programs that are accessible to staff in both direct client care and management roles, and to balance this with providing more detailed teaching to individuals who are interested.

4. *Do you think anything about the course could be changed to improve outcomes in regard to your service?*

The majority of respondents made no suggestions for changes when asked to comment on how the course could be changed to improve service outcomes, other than those already mentioned in relation to their work (question 3 above).

5. *What are your views regarding the possibility of delivering some of the teaching on-line?*

When asked about the idea of delivering some of the teaching online, there were mixed views. Five respondents indicated that they believed it was a positive idea, based on the hope that a greater number of mental health workers would be able to receive the training:

*I think if it means it would reach people who wouldn't otherwise be able to attend the course, then I think that would be good... rather than not at all. Sounds like a good idea.*

However, the majority of respondents ( $N = 9$ ) expressed ambivalence. Some indicated specific sessions that could be delivered in this format, particularly the working effectively with interpreters' session. But the perceived benefits of direct teaching emerged as a key theme, including interaction within the group and with facilitators. Certain interactive sessions such as the consumer and carer session were felt to be most valuable in the current format. Other respondents indicated the potential benefit of using a combination of online and direct teaching methods.

*Some of the theoretical stuff could be useful if it was online, but I also think that we would lose... the facilitators were very good and we would lose that if it was just online. You wouldn't get as much out of it with the facilitators and other participants present.*

6. *Were any topics not covered that you would have liked to have included?*

Most respondents indicated that the training program was comprehensive and did not identify any topics that needed to be added.

*I don't think so. I feel this training ... covered all sections in mental health, collaborations, and people who make change should be more able to make change in services. I think it was comprehensive, ... making people believe that it's worthwhile attending.*

However, three respondents suggested that it would be worthwhile to give more time: to the experiences and perspectives of CaLD consumers; to Foundation House on the impact of trauma in Module 1; to post-migration experiences and difficulties; and to the impact of emerging communities on the host culture.

7. *Do you have any additional comments?*

Asked whether they had any additional comments, two respondents remarked that the training was one component of service development work that will occur over a longer period of time.

*I found the modules very, very helpful. A lot of the detail of the content I've probably lost... but I remember thinking at the time that this is really, really valuable. So, I guess it would be up to me, [and] everybody to actually use the material ... and to go back and actually revise it. And maybe what we need to do as an organisation is to get together with others who attended the course and to have a refresher process, or to think about... how we can best move forward from here.*

Other respondents pointed to the need to provide the training to a greater number of staff, as:

*... like myself, staff don't realise what they don't know. And unless you get to training like that, they never will. And if there was some way everybody could get to that training it would be excellent. And I know that all the people who attended here said it was fabulous. We had quite a few staff get through all six days of training which is really great. I would have expected a higher dropout rate, so I think it proves the value.*

One participant thought that there was too long a gap between sessions (there was approximately one month between each module); another found the course ...*at times very clinical... but I still found it increased my knowledge base*; while another suggested that more information on services and resources in the form of a brochure would be helpful. It was also suggested by one respondent that if they were contacted again for a follow-up interview in 12 months time they might have *better answers for you*. Remaining comments praised the course and expressed appreciation to the VTPU.

## Discussion

In a context where 17.6% of Victoria's population was born in a country where English was not the first language, it is the role of the VTPU to build the capacity of mental health service providers to provide equitable and culturally competent services to CaLD communities. The aim of this project was to determine whether mental health professionals showed evidence of increased cultural competence and service responsiveness following participation in the 6-module VTPU course in *Culturally Competent Mental Health Service Provision for a Multicultural Society*. The study also aimed to evaluate the usefulness and effectiveness of the training approach. The 6-day duration and depth of the course differed from CCT programs reviewed by Bean (2006), which averaged a duration of six hours (although the CCMHSP was offered as single modules or as a complete course). A total of 92 participants from a range of mental health professions attended the course, with 52 completing at least five, and 33 completing all six modules. A pre- and post-training design was employed, with quantitative and qualitative summative, formative and impact measures.

### Cross-Cultural Confidence in Mental Health Practice and Service Responsiveness (CCMHP)

Items comprising the Cultural Competence sub-scale of the CCMHP – identified through factor analysis - elicited participants' ratings of their confidence, knowledge and skills in working with CaLD clients. Mean scores on this sub-scale increased significantly from pre- to post-training. The items comprising the Cultural Practice sub-scale rated the extent to which cultural factors influenced participants' practice with CaLD clients, and the responsiveness of their service to CaLD clients and carers. Post-training scores on this sub-scale increased at a level approaching significance, while the CCMHP total scale score increased significantly. No factors associated with participants' work experience or role, type of mental health service, previous cross-cultural training and background were associated with changes in scores on either the Cultural Competence or Cultural Practice sub-scales. These findings suggest the CCMHSP course contributed to an increase in trainees' sense of cultural competence, regardless of their background, while there were also improvements in cultural practice but these were more attenuated. The finding of an increase in trainees' sense of cultural competence is consistent with previous findings of significant improvements in awareness, confidence and knowledge following cross-cultural training (Bean, 2006; Hutnik & Gregroy, 2007; Lefley, 1986b; Stolk, 2005). Although trainees' ratings on the Cultural Practice sub-scale showed a less marked improvement, findings on the Cross-Cultural Case Study, reported below, provide evidence of the potential for changes in practice.

### Cross-Cultural Case Study responses

Participants were presented with a Cross-Cultural Case Study at the commencement of the course and immediately following Module 5, asking them to list cultural factors that might be relevant to the assessment and treatment of this case. The content of the



case incorporated issues from each module in the CCMHSP course. As predicted, the mean number of responses increased significantly from 8.75 ( $SD = 3.12$ ) before training to 13.77 ( $SD = 4.45$ ) following training, indicating that participants had gained a greater breadth of understanding of the cultural factors that might influence presentation and treatment of a CaLD case. As with the CCMHP, no participant background factors were associated with changes in the mean number of responses.

There were also no significant correlations between scores on the CCMHP Cultural Competence and Cultural Practice sub-scales and the number of Case Study responses, indicating that there was no relationship between participants' self-ratings on the CCMHP sub-scales and their capacity to identify cultural factors in a case vignette. This is consistent with findings that self-reported cultural competence on the Cross-Cultural Counselling Inventory-Revised was not related to trainees' multicultural case conceptualisation ability (LaFromboise, Coleman & Hernandez, 1991). This raises doubts about the adequacy of self-ratings of cultural competence as sole evaluation measures.

Qualitative analysis of the Case Study showed that response themes changed in focus from pre- to post-training. While *Post-migration, refugee and settlement experiences* was the most frequently mentioned theme both pre- and post-training, there was a significant change away from the pre-training focus on the client's *Cultural and linguistic background* (e.g., birthplace, English proficiency) to an increased post-training focus on post-migration/flight and settlement experiences. Reference to *pre-migration and refugee experiences* also increased post-training. Although the theme, *Differentiate idioms of distress and beliefs from mental illness* was the second most frequently mentioned before training, there was no increase in reference to this theme post-training. With the exception of *Risk assessment: protective cultural factors*, which increased from 2.9% to 5.5% of themes post-training, there were no notable changes towards the more clinically-oriented cultural factors following training.

In part this may be attributable to the finding that a number of participants already demonstrated a sound understanding of relevant cross-cultural factors before training. Nevertheless, the findings from the Case Study clearly demonstrate that the majority of participants were able to consider a broader range of cultural factors, with some also showing evidence of a greater depth of understanding. Furthermore, the increased focus in responses on post-migration experiences suggests that trainees gained a greater understanding of the need to take into account the context in which the CaLD client may be living. While the Case Study does not provide a direct measure of transfer to mental health practice comparable to, e.g., video-taped role plays of intervention skills (Lefley, 1986a), it provides a reasonable approximation.

## **Post-training feedback**

### *Post-Training Feedback Form*

Post-training Feedback Forms and reflective learning sessions provided formative evaluation data on the effectiveness of the content of each module and on the training

approaches used. Feedback from these evaluation forms for modules delivered earlier in the year was used to make minor modifications to subsequent delivery of each module. The relevance and usefulness of the content of sessions in all modules received mean ratings ranging from 4.5 ( $SD = 0.79$ ; on a scale of 1 – 5) for Service Development Strategies in Module 6, to 4.9 ( $SD = 0.42$ ) for Cultural Beliefs and Explanatory Models in Module 4. The case studies, activities and workshop handouts received similarly high ratings. The overall course was given a mean rating of 4.7 ( $SD = 0.38$ ) across all aspects of the course. These are high ratings when compared with a mean usefulness rating of 3.9 on a scale of 1 - 5 reported by Hutnik and Gregory (2007), but comparable to a mean of 3.5 on a 1 - 4 scale found by Stolk (2005).

Qualitative analysis of open-ended written responses on the PTFF showed that aspects of the course perceived to be most useful or interesting, were the case studies, visual aids such as photos and DVDs, and role plays. Case studies, used in four of the six modules, were seen as clarifying the relationship between theory and practice. Visual aids, used for example in the session on Mental Health, Migration and Refugee Status, were perceived as lending power to the impact of refugees' experiences. DVD clips were also seen as useful in demonstrating interpreting practice and negotiation of explanatory models. Similarly, role plays were valued for providing experience in these skills. Also considered useful were group interactive exercises, such as used to highlight participants' own cultural values in Module 2, and the content and framework provided by a number of sessions, such as Emotion across Cultures. The Somali Mental Health Project in Module 6 was considered to provide a good example of working with CaLD communities. Further qualitative comments expressed praise for the particular module, and for the course overall, describing it as very well presented, balanced and enjoyable.

The most frequently mentioned suggestions for changes to the course included more interactive exercises and visual aids, and changes in the duration of the course and intervals between modules. However, these suggestions need to be interpreted in the context that interactive exercises and visual aids were amongst the most highly valued aspects of the course, and 50% to 80% of participants recommended that no changes were needed to a module or made no comments in response to this question. Nevertheless, the recommendations were considered in a subsequent review of the course.

### *Reflective Learning Sessions*

The reflective learning sessions conducted at the end of each module aimed to encourage participants to reflect on how the learning from the module might influence their mental health practice. Qualitative analysis showed that the responses generally reflected and added depth to the feedback from the PTFF. Major themes identified included Training Format, Cultural Competence, Service Development, and Collaboration and Community Development. In relation to the Training Format, case studies, interactive activities, role plays and DVDs were perceived as valuable and

useful in translating theory into practice. Comment was also made on the value of the stories of CaLD consumers and carers. Participants identified some limitations to the modules including a sense of being overwhelmed by the content of Module 1 on refugee experiences. Some participants suggested a greater level of involvement of CaLD presenters in the modules to obtain their perspectives. Suggestions were also made to modify the role play on negotiating explanatory models to make it more immediately relevant to the participants. While some participants thought the duration of the course should be condensed, it was also acknowledged that it would be difficult to choose what aspects to omit.

Respondents indicated that the modules had given them a greater sense of cultural competence by providing them with an increased understanding of issues faced by CaLD consumers and carers, as well as enhancing their knowledge and skills in practice, such as working with interpreters, and eliciting CaLD clients' explanatory models. Some participants expressed a desire for more information on specific cultures, indicating a lack of understanding of the purpose of the explanatory model framework. This suggests that there is a need in future training to further emphasise the importance of avoiding assumptions regarding a consumer's cultural background, and the risks of stereotyping.

Participants identified development of their services' cultural responsiveness as an opportunity to disseminate what they had learned during the course. Staff and clinical review meetings were perceived as forums to share culturally relevant information with colleagues, including on-line and other resources identified during the course, and service documentation could be reviewed to incorporate CaLD issues. Service responsiveness could be increased by appointing CaLD consumer advocates, and increasing the number of staff receiving the training was seen as a priority. Collaboration and engagement with CaLD and related community agencies was perceived as an important means of linking with CaLD communities and improving their access and quality of care.

While most participants expressed clear benefits from learning about transcultural mental health, some were concerned that they lacked the capacity to influence and implement change in their service, pointing to the need for service leadership at a managerial and clinical level. This is consistent with recommendations that, for cultural competence to be effective, it needs to be embedded at all organisational levels (Betancourt et al., 2003; Bhui et al., 2007, NTAC, 2004). As part of its overall strategy, the VTPU is addressing these issues by collaborating with mental health service managers and senior staff to facilitate implementation of service change. In addition, a secondary consultation program is being introduced to aid course participants to consolidate learning from the course, extend the knowledge and skills to other staff, and to facilitate transfer to practice.

## **Follow-up interviews**

The short-term impact of the Course was evaluated through follow-up interviews with

17 participants 4 – 7 weeks after its completion. Most of the respondents indicated the training had enhanced their work with culturally diverse clients, having gained a greater insight into the experiences of CaLD clients and carers, as well as having acquired skills in cross-cultural mental health practice. An increased recognition was expressed by most respondents of the need for development of their services' cultural sensitivity, and reported being involved in this process. Some respondents suggested that the impact on their practice and their service's responsiveness might be better evaluated after a longer period as their awareness increased and as service development work took effect, anticipating that this would be a longer-term project.

As in the post-training feedback, some respondents suggested that their work and service outcomes could be improved if the course was abridged, enabling more staff to attend. However, others approved of the course duration, and some respondents even suggested a more extensive program with more case studies, and more time for refugee and CaLD consumer experiences. Other respondents considered the course comprehensive and recommended no changes. In response to the suggestion that the course might be delivered on-line, there were divided views: some respondents endorsed the idea, as the training would be available to more mental health workers, but others thought that the particular benefits of interaction with the group and the facilitators would be lost. Additional comments highlighted the extent to which the course was valued and perceived as an impetus to action by participants, as illustrated by two response extracts:

*Like myself, staff don't realise what they don't know. And unless you get to training like that, they never will. And if there was some way everybody could get to that training it would be excellent.*

*I remember thinking at the time that this is really, really valuable. So, I guess it would be up to me, [and] everybody ... to get together and to have a refresher process, or to think about... how we can best move forward from here.*

## **Transfer to practice**

As previously noted, the cross-cultural training programs reviewed by Bean (2006) did not demonstrate transfer to practice in the workplace partly because of the brevity of the programs and the absence of organisational measures of cultural competence. The VTPU 6-module, 6-day course was of a longer duration than the courses reviewed by Bean (2006). Moreover, a specific strategy of the VTPU course has been to incorporate a training module on organisational change and responsiveness to CaLD clients. The present training evaluation has provided some evidence of transfer to mental health practice through the Cross-Cultural Case Study, and improvements in organisational responsiveness through the follow-up interviews. However, these issues are being investigated in greater depth in a second stage of the evaluation project. In collaboration with the two pilot AMHSs, service development and capacity-building initiatives, which were designed to improve organisational cultural competence, are currently being implemented and evaluated.

## Limitations

There were a number of limitations to the present study. First, the post-training Cultural Case Study was administered after module 5, which meant that participants were less likely to incorporate service and community development issues into their responses, topics that comprised the content of module 6. The second limitation was that the reflective sessions, conducted at the completion of each module, were led and recorded by the VTPU trainers. This may have influenced the tone of participants' responses. And thirdly, follow-up interviews to evaluate the impact of the course were conducted 4 – 7 weeks following completion of the course. A six or 12 month interval would have allowed participants more time to process and endeavour to apply their learning in practice, as remarked by some respondents to the interviews. However, the need to prepare and update the training course for 2010 prohibited a longer delay before the interviews.

## Conclusions

The convergent findings of the qualitative and quantitative pre- and post-training evaluations of the VTPU's course in *Culturally Competent Mental Health Service Provision for a Multicultural Society* have clearly demonstrated that participants' self-ratings and perceptions of their cultural competence increased following training. They also showed a greater understanding of the cultural issues that might influence a CaLD case presentation, suggesting increased awareness and knowledge, and the potential for increased skills in practice. Participants rated the course as relevant in its content and interesting in its training approach, and identified opportunities for development of service responsiveness and CaLD community development. The benefits of the course applied regardless of the type of participants' mental health service (whether PDRSS or clinical MHS), profession, previous cross-cultural training, and cultural background.

The implication of the findings is that CaLD service users and their families are likely to benefit in terms of improved service access and treatment quality and equity when mental health workers participate in this course. As a major proportion of Victoria's mental health workforce is still to undertake such training, it is recommended that the course continues to be delivered, taking account of some of the changes recommended by participants. In particular, important recommendations that emerged included the need to provide in-depth training to a larger number of staff, abridged training to all staff, and the need for training to be delivered in the context of service development.

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# Appendix A

For office use only: Evaluation No ..... Site: 1. GV 2. VTPU 3. WMMH 1. Continuing 2. Single module	Your name* .....  Date .....
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**Victorian Transcultural Psychiatry Unit**  
***Culturally Competent Mental Health Service Provision***  
***for a Multicultural Society 2009***

**Post-Training Course Evaluation Form**  
**Cross-Cultural Confidence in Mental Health Practice**

Thank you for participating in the Victorian Transcultural Psychiatry Unit's (VTPU) new program in *Culturally competent mental health service provision for a multicultural society*. To enable the VTPU to complete evaluation of this program, please complete this brief post-course evaluation measure.

\*To allow us to link evaluations over time, we would appreciate if you would write your name at the top of the page. By providing us with your name, we understand that you agree to participate in the evaluation process. Your name will not be recorded on the evaluation database. Thank you for your time in contributing to the evaluation.

The following questions ask about your cross-cultural confidence and about issues in cross-cultural practice.

Please circle the appropriate answers	1	2	3	4	5
1. At the completion of this course/ module, how <i>confident</i> do you feel about cross-cultural mental health practice?	Not confident	A little confident	Somewhat confident	Moderately confident	Very confident
2. The knowledge and skills needed in mental health practice with CALD clients and with Australian-born clients are:	Very different	A little bit different	Almost the same	The same	Very much the same
3. How would you rate your knowledge and skills in mental health practice with CALD clients, compared with Australian-born clients? With CALD clients my knowledge and skills are:	Not as good	Almost as good	The same	Better	Much better
4. Awareness that a client is of a different cultural and linguistic background than my own influences my mental health practice;	Not at all	A little bit	Somewhat	Moderately	A lot
5. Generally speaking, how responsive is your mental health service to clients and carers of culturally and linguistically	Not at all responsive	A little responsive	Somewhat responsive	Moderately responsive	Very responsive
6. In my workplace I experience no barriers to implementing culturally responsive mental	Totally disagree	Disagree a little	Agree somewhat	Agree	Totally agree

Thank you for your help with the evaluation.

## Appendix B

For office use only: Evaluation No ..... Site: 1. GV 2. VTPU 3. WMMH 1. Continuing 2. Single module	Your name* .....  Date .....
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### **Victorian Transcultural Psychiatry Unit** ***Culturally Competent Mental Health Service Provision*** ***for a Multicultural Society 2009***

#### **Case study: Cultural factors in mental health practice**

*Please read through this case, thinking about what cultural factors you need to consider, and what additional information you need to assess and treat this client.*

Your responses will enable the trainers to determine what issues need to be addressed in the other modules of this course. \*In addition, participants continuing on to complete all modules, will be able to judge how much they have learnt, as they will be asked to complete this case study again at the end of the course and will be given back this form, for comparison. For this reason, we would appreciate if you would fill in your name at the top.

Ahmed is a 30-year old man who has been assessed by a CAT Team. The CATT were called by his GP because Ahmed became aggressive when the GP wanted to refer him to a mental health service because of his unusual symptoms, which had no physical diagnosable cause. He complained of sleeplessness, pain in the heart, and heat and crawling sensations in the head. He told the GP that this was due to the evil influence of an envious neighbour, with whom he'd engaged in arguments. At first Ahmed, refused to talk to the CATT clinicians, who arranged to have him admitted. Following consultation, staff were able to engage Ahmed. On assessment he further reported that the figure of a man came into his bedroom at night threatening to strangle him. He also believed that people in the street were spies watching him, and complained of discrimination trying to find accommodation. Although contrary to his beliefs, he acknowledged that thoughts of taking his life had entered his mind, as he had found life in Australia difficult and disappointing.

# Appendix B (cont'd)

*Please write down what cultural factors you would need to consider and what additional information you need to know. Please keep your responses brief*

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# Appendix C

For office use only: Evaluation No ..... Site: 1. GV 2. VTPU 3. WMMH 1. Continuing 2. Single module	Your name* .....  Date .....
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**Victorian Transcultural Psychiatry Unit**  
***Culturally Competent Mental Health Service Provision***  
***for a Multicultural Society 2009***  
**Module 2: Values, the sense of self and emotions across cultures**  
**Post-Training Feedback Form**

Thank you for participating in today's module. Please rate how *relevant/useful* you found today's sessions and training approaches by circling the appropriate number.

Session 1	Not relevant/ useful	A little	Somewhat	Moderately	Very
1. Cultural Values and the Sense of Self: Influence on Mental Health Practice	1	2	3	4	5
2. Use of case studies in this session	1	2	3	4	5
3. Activities in this session	1	2	3	4	5
4. Handouts/resources for session	1	2	3	4	5

5. What aspects of the session did you find most useful or interesting?

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6. What changes would you suggest to improve this session in the future?

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# Appendix C (cont'd)

Session 2	Not relevant/ useful	A little	Somewhat	Moderately	Very
7. Understanding Emotion Across Cultures	1	2	3	4	5
8. Use of case studies	1	2	3	4	5
9. Activities	1	2	3	4	5
10. Handouts/resources	1	2	3	4	5

11. What aspects of the session did you find most useful or interesting?

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12. What changes would you suggest to improve this session in the future?

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13. Other comments

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Thank you for your participation today and for taking the time to complete this questionnaire. Mod 2 Post-training Eval form 270309

## Appendix D

### REFLECTIVE LEARNING SESSION

Werribee Mercy Pilot Site

Module 5: August 14<sup>th</sup> 2009

Key points raised	Possible strategies for service to consider	VTPU follow-up questions

- **How will this training focusing on cross-cultural risk assessment influence your work practice and view of CaLD clients?**
- **What barriers to implementation do you see?**
- **How might you overcome barriers to implementation?**
- **Does the course content cover areas of need and are the learning methods appropriate?**
- **How do you think this content can be disseminated across your services?**

**Session Notes**

## Appendix E

### Post-Training Questions for Follow-Up Interviews

Inform them:

*"Thank you for your participation in this interview which will take about 15 minutes. The purpose of the interview is to assess your experience of the VTPU training course that you attended and to provide additional feedback to the VTPU that will guide the development of further training programs that the VTPU will provide. This interview will be transcribed for analysis and so I will be making an audio-recording of the interview. All of the responses that you provide will remain anonymous. I have 9 questions to go through with you. To begin with..."*

Use the following standard prompts to elicit further information:

*"Would you elaborate on that?"*

*"Could you say more about that?"*

*"That's helpful. Can you tell me a bit more detail?"*

1. Has the training had an impact on how you work with CALD clients?
2. Has the training had an impact on your involvement in change within your service?
3. What do you consider to be the most important outcomes of the course in regard to your work?
4. What do you consider to be the most important outcomes of the course in regard to your service?
5. Do you think anything about the course could be changed to improve outcomes in regard to your own work?
6. Do you think anything about the course could be changed to improve outcomes in regard to your service?
7. What are your views regarding the possibility of delivering some of the teaching on-line?
8. Were any topics not covered that you would have liked to have included?
9. Do you have any additional comments?

THANK YOU FOR YOUR TIME

# Appendix F

## Case Study superordinate and subordinate themes and frequency of responses

Theme No.	Themes	Pre-training	%	Post-training	%
<b>1. Demographic: Cultural linguistic background</b>					
1	Country of birth; investigate birthplace/cultural background	24	4.6	20	2.7
2	Ethnicity	3	0.6	11	1.5
3	Language spoken	18	3.4	7	1.0
4	English proficiency/literacy	20	3.8	25	3.4
5	Need for interpreter	22	4.2	11	1.5
<b>2. Pre-migration/refugee experiences</b>					
6	Refugee / migrant status/ residential status / legal status	10	1.9	19	2.6
7	Refugee/migration experiences; pre-arrival; reasons for migration	33	6.3	53	7.3
35	Trauma/torture, detention hx	19	3.6	31	4.2
<b>3. Post-migration/flight settlement experiences</b>					
8	Refugee/ migration experiences – post-arrival, time in Australia	28	5.3	34	4.7
36	Expectations of life in Australia, disappointment	6	1.1	14	1.9
9	Family location: nuclear / extended family/ family support / loss of family/ need to sponsor	32	6.1	50	6.8
10	Social/community /religious support – non-family or not defined / accepted in community	36	6.9	44	6.0
11	Employment, education: current and past – issues, finance, accommodation, current situation/stressors	19	3.6	36	4.9
12	Role, role loss, change in economic situation	0	0.0	10	1.4
13	Acculturation, identity issues, values	15	2.9	40	5.5
<b>4. MH Worker/client relationship; cultural consultation</b>					
14	Clinician's own cultural awareness: culturally appropriate behaviour, e.g. remove shoes, appropriate diet	11	2.1	2	0.3
15	Issues in clinical relationship, trust	3	0.6	3	0.4
16	Gender / political issues – with clinician, interpreter, others	9	1.7	9	1.2
17	Cultural consultation; religious leader; carer involvement – service responsiveness	9	1.7	7	1.0
<b>5. Clinical assessment: differentiate idioms of distress, beliefs</b>					
18	Emotion expression- cultural differences in / idioms of distress / depression; grief, loss; physical vs mental expression	7	1.3	23	3.1
19	Beliefs / religion, spirituality, [superstition] investigate	46	8.8	56	7.7
20	Differentiate beliefs from mental illness/ cultural overlay in psychopathology / investigate evil influence of neighbour	14	2.7	11	1.5
31	Mental health services in own country & here: attitudes to, stigma, shame, barriers	20	3.8	9	1.2



## Appendix F (cont'd)

<b>6. Clinical assessment: investigate explanatory models</b>				
21 Explanatory model questions (1), e.g. culture's view of, attitudes to mental illness, interpretation of symptoms	25	4.8	36	4.9
34 Explanatory model questions (2): treatment needed/used e.g. religious interventions	3	0.6	21	2.9
32 Negotiate explanatory models – ensure understanding of mental health service Ax, interventions	6	1.1	2	0.3
33 Culturally sensitive intervention	6	1.1	4	0.5
<b>7. Clinical assessment: differentiate delusions</b>				
24 PTSD symptoms – assess for	9	1.7	8	1.1
25 Racism, prejudice, discrimination experiences/differentiate from paranoia	12	2.3	10	1.4
26 Justifiable suspicion/differentiate from paranoia: who is the figure? hx of violence, authoritarianism in country of origin; inter-tribal conflict in Australia	12	2.3	22	3.0
<b>8. Clinical assessment: risk assessment; protective factors</b>				
27 Risk of suicide/violence: beliefs re suicide	9	1.7	27	3.7
28 Factors protective of suicide risk	6	1.1	13	1.8
<b>9. Clinical assessment, diagnosis: standard</b>				
23 Drug abuse; other substances	3	0.6	14	1.9
22 Psychosis – assessed to have mental illness, paranoia, Ahmed denies mental illness; educate	4	0.8	1	0.1
29 Clinical assessment – standard (non-cultural, not mentioned above) e.g. psychiatric hx, family hx	26	5.0	48	6.6

As required by Standard 6 of the Victorian Department of Health's 2009 *Cultural Responsiveness Framework: Guidelines for Victorian Health Services*, "Staff at all levels are [to be] provided with professional development opportunities to enhance their cultural responsiveness". A suggested measure of this standard is "Demonstrated post-training staff evaluation on effectiveness and application of professional development".

This report exemplifies such an evaluation.

