Culturally and Linguistically Diverse (CALD) Training

for Health Providers Working in the Emergency Quota Refugee Regions

~ Pre and Post CALD Training Evaluation Study ~

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1. Introduction

The New Zealand Government accepts 1000 quota refugees annually for settlement in New Zealand. From 2015, the New Zealand Government accepted an additional 600 Emergency Quota Refugees (EQR) from Syria for resettlement in Palmerston North, Wellington, Christchurch and Dunedin. Waitemata DHB eCALD® Services ("eCALD® Services") have been providing Culturally and Linguistically Diverse (CALD) group Cultural Competency online and face to face training for the health workforce since 2010 (Waitemata DHB eCALD® Services, 2014). To support the health providers and services in the regions where Syrian EQR refugees are being settled, the Ministry of Health funded eCALD® Services to provide face to face and online CALD cultural competency training courses for the 2017/18 year.

The "Culturally and Linguistically Diverse (CALD) Training for Health Providers Working in the Emergency Quota Refugees Regions - Pre and Post CALD Training Evaluation Study " ("the study") has been undertaken to assess the impact of CALD cultural competency online and face to face training on learner's attitudes and behaviours when working with CALD patients and families, as well as improving patient experience in EQR settlement areas. Learners who completed the training between 1st March 2017 to 30th June 2017 were invited to complete a pre and post training online survey. The aim of the survey was to ascertain the impact of the training provided in the following areas:

- To assess the attitude and behaviour changes of learners (LEARNERS) who have completed CALD Training
- To assess the usefulness of the CALD courses (TRAINING) in terms of the value and usefulness to the learners in practice
- To assess if there are systemic or other barriers that may impact on the provision of culturally appropriate services to CALD patients/families.
- To assess whether LEARNERS have improved their cross-cultural skills which may lead to improved patient experience

1.1 Background

CALD Cultural competence education for health professionals aims to ensure that people from culturally diverse backgrounds receive equitable and effective health care in New Zealand. CALD cultural competency education has emerged as a strategy in immigrant receiving societies in response to evidence of health disparities, structural inequalities, and poorer quality health care and outcomes among people from CALD backgrounds (Horvat, 2014). New Zealand Health Needs Assessments for Asian, Middle Eastern, Latin American and African populations show disparities in health outcomes compared with other population groups (Mehta, 2012; Perumal, 2011; Scragg, 2010; 2016). There is strong evidence that cultural competence training for health care professionals improves providers' knowledge, understanding, and skills for treating patients from culturally and linguistically diverse backgrounds (Gallagher & Polanin, 2015; Like, 2011; Renzaho et al., 2013; Truong et al., 2014).

The Health Practitioners Competence Assurance Act (HPCAA) (2003) requires health practitioners to demonstrate cultural competence as part of their registration requirements, increasing CALD cultural competence training uptake as part of professional development for medical, nursing and allied health practitioners across New Zealand. CALD Cultural Competency Training has been made available to the health workforce in the Auckland region since 2010 and nationally since 2015. Waitemata DHB eCALD® Services provides a web portal www.eCALD.com for health practitioners to access a range of online and

face-to-face CALD Cultural Competency courses, as well as online cross-cultural resources. There is also evidence that eCALD® Training is effective in terms of increased knowledge of participants.

In 2011, an independent evaluation of Waitemata District Health Board's CALD Cultural Competency Training was undertaken by the University of Auckland (2012). The findings from the evaluation show that, overall, completion of Module 1 of the CALD programme had a significant impact on participants' cultural competence. Health Professionals reported increased positive behaviours and attitudes/sensitivity towards CALD patients. Participants found Module 1 to provide many useful aspects with respect to increasing their cultural competency and described various ways in which they had utilised learning in practice. They reported increased knowledge of cultural differences, including values, health beliefs, religious beliefs, gestures and customs, and better skills when interacting and communicating with CALD patients. They also described ways in which their awareness of and sensitivity towards CALD patients had been enhanced. Moreover, according to the qualitative evidence obtained, participants in CALD Module 1 reported a heightened awareness of their own culture and how their own cultural beliefs impacted on how they viewed other cultures different from their own.

Emergency Quota Refugees

In September 2015, the Government announced that New Zealand would accept 750 Syrian refugees in over the next two and a half years in response to the ongoing conflict in Syria. Of the 750 places offered, 600 were allocated to a special emergency intake above New Zealand's annual refugee quota of 750 (until 2015), and 150 places were offered within the existing 2015/16 annual quota. The Syrian Emergency Quota refuges were selected for resettlement from refugee camps in Lebanon.

What services are provided for refugees once they arrive in New Zealand?

Quota refugees are given permanent residence on arrival in New Zealand and spend their first six weeks at the Mangere Refugee Resettlement Centre. While there, they complete a reception programme to support living and working in New Zealand and English language. They also complete medical screening and treatment and mental health assessments.

A number of government agencies and NGOs are involved in the settlement of quota refugees, including the Ministries of Health, Education and Social Development, Work and Income, Housing New Zealand and NZ Red Cross. New Zealand Red Cross is contracted by Immigration NZ to provide settlement support in the community over the first 12 months. This includes an orientation programme and connecting refugees to services they require such as doctor's appointments, English language, education and employment.

CALD Cultural Competency Training

Waitemata DHB eCALD® Services (2014), have been providing CALD Cultural Competency Training online and face to face since 2010. The course design principles include the use of evidence-based research on culture to inform content development. The design includes the adoption of Hofstede's (2001) model of cultural values which provides the theoretical framework for recognising differences in cultural values. These includes understanding collective versus individualistic social values; understanding how status and rank is valued (high power distance) in traditional societies and less valued in western societies (low power distance); understanding the emphasis on social rules, certainty and compliance in traditional societies (high uncertainty avoidance) compared to western societies which are characterised by social choice and fewer rules (low uncertainty avoidance)and understanding adherence to strict gender roles (masculinism) in traditional societies versus greater equality in gender roles in western society (feminism). The courses are pedagogically designed, incorporating theoretical, experiential and reflective knowledge to introduce and reinforce learning. The use of multi-media scenarios, interactive exercises, quizzes and case studies are used in the courses to enhance learners' understanding.

The overall goal of the training programme is to enable health practitioners to gain the critical cultural understanding, awareness, sensitivity, knowledge and skills to work with CALD patients, their families and communities. The courses are designed to ensure contextual and layered learning experiences that progressively enable learners to increase and enhance their:

1. *Awareness* of their own culture and attitude towards cultures different from their own
2. *Cultural sensitivity* when working with CALD patients
3. *Knowledge* of cultural differences such as values, health beliefs, religious beliefs, health seeking behaviours, customs, gestures, as well as awareness of the migrant journey and the refugee experience etc which impacts on the patient-health practitioner interaction/communication/engagement/service uptake/service responsiveness.
4. *Skills* to work cross-culturally. The ability to work with and to communicate effectively with CALD patients.

The aims of the CALD training programme are to: increase the health workforce's level of consciousness and confidence to work with CALD patients and their families; enhance the cross-cultural interactions in the long term; increase CALD patients' satisfaction with the services delivered and reduce miscommunication, misdiagnosis, non-compliance with treatment and follow up, and disengagement.

The suite of CALD Cultural Competency Training modules for "Working with CALD Patients" comprise:

- CALD 1 - Culture and Cultural Competency [*pre-requisite*]
- CALD 2 - Working with Migrant (Asian) Patients
- CALD 3 - Working with Refugee Patients
- CALD 4 - Working with Interpreters
- CALD 5 - Working with Asian Mental Health Clients
- CALD 6 - Working with Refugee Mental Health Clients
- CALD 7 - Working with Religious Diversity
- CALD 8 - Working with CALD families – Disability Awareness
- CALD 9 - Working in a Mental Health Context with CALD clients
- CALD 10- Working with CALD Child and Adolescent Mental Health

The courses are CME/CNE/MOPS accredited and are available in e-learning and face to face formats. Courses can be accessed via the eCALD® Services website www.ecald.com.

Additionally there are a range of paperback, online downloadable and online HTML supplementary resources for health providers to increase their cultural knowledge and to gain additional information on culturally appropriate approaches for working with CALD patients/clients from Asian, Middle Eastern and African cultures. These include:

- Cross-Cultural Resource for Health Practitioners Working with CALD Clients: (*this toolkit provides communication tips as well as information about health beliefs and practices and family values for 7 Asian and 7 Middle Eastern and African cultures. It includes guidelines for practitioners working with interpreters and with each of the cultures).*
- CALD Working with religious diversity: *(includes principles of Confucianism, Taoism, Folk Religion, Buddhism, Traditional Chinese Medicine)*
- CALD Working with CALD clients: Disability Awareness (Disability in Islam cultures, some African and Asian cultures)
- CALD Working with Asian Mental Health Clients
- CALD Working with Middle Eastern and African Mental Health Clients
- CALD Family Violence Resource for Practitioners: Working with Asian, Middle Eastern and African Clients

- CALD Health of Older People Resource for Practitioners: Working with Asian, Middle Eastern and African Clients
- Maternal Health for CALD Women: Resource for Health Providers working with Asian, Middle Eastern and African Clients
- CALD Child and Adolescent Mental Health: Resource for Health Providers working with Asian, Middle Eastern and African Clients add Child and Adolescent

CALD cultural competency courses take a universalist approach to training based on the perspective that cultural competence can be taught through reflective awareness, empathy, active listening techniques, communication and clinical decision-making skills (AHRQ, 2014).

1.2 Aims of the evaluation study

The aims of the study were to evaluate face to face and online CALD cultural competency course post training improvements in learner's attitudes and behaviours when working with CALD patients and families, as well as improvement in patient experiences. To this end, an evaluation was designed to address the following questions:

1. What impact has completion of CALD face to face training had on learner's cultural competence? More specifically, what was the impact on learner's attitude and behaviour changes when working with refugee patients and families?
2. How useful was the CALD Training in terms of improving the learner's practice?
3. Are there are systemic or other barriers that are impacting on the provision of culturally appropriate services to refugee patients?
4. Did learners improve their cross-cultural skills which led to improved patient experience?

2. Method

All those learners who completed a CALD cultural competency face to face and online courses in Palmerston North, Wellington, Dunedin and Christchurch between 1st March 2017 and 30th June 2017 were invited to participate in the post training evaluation study. eCALD® Services continued to send reminder emails to participants until the evaluation closure date, to ensure maximisation of participant numbers. All those recruited were invited to complete a questionnaire three months after completion of a face to face CALD cultural competency training course. Table 1 shows the numbers of those invited to participate who completed the post questionnaire.

2.1 Recruitment and sample

Participants were selected because they had completed one or more of the CALD Cultural Competency face-to-face and online ecourses delivered by eCALD® Services, which were organised and promoted by Learning and Development or the course coordinators in Dunedin, Invercargill, Wellington, Porirua, Wairarapa, Palmerston North, Hamilton or Christchurch.

All Learners who had completed the Training between 1st March 2017 to 30th June 2017 were sent a Pre and Post training online survey form in September 2017, 3 months after they complete the Training. A further reminder was sent to Learners in November 2017. The Pre and Post Training Survey participation

was voluntary. As an incentive participants were invited to enter a prize draw for movie vouchers. A sample of the Pre and Post Training Online Survey Form is included in Appendix 1.

The Post Training Survey online questions were designed to include 10 quantitative questions and 1 qualitative question. The following describes the purpose of the survey questions:

- Quantitative Questions (2): to assess learners' experience working with CALD patients/families
- Quantitative Questions (6): to assess the value of the CALD training using pre and post scores on individual items measuring behavioural and attitudinal/sensitivity scales
- Quantitative Question (2): to gather participants' experiences of the Training and systemic or other barriers faced by learners that impact on their provision of culturally appropriate services for refugee patients/clients.
- Qualitative Question (1): to gather examples of how undertaking the course might have positively influenced learner's thinking and/or practice such as interactions, engagement, cultural assessment/screening/intervention which they believe would indirectly lead to improvement in patient experience.

We invited 281 participants to participate in the Pre and Post Online Training Online Survey and of these 100 were unable to be contacted due to emails returned undelivered. Out of the 181 successfully sent invitations we received 59 (32.6 % response rate) responses to the survey.

2.2 Instruments

The questionnaire incorporated the Cultural Competency Assessment Instrument (CCAI) for health care providers (Doorenbos et al., 2005) (See Appendix 1) and was completed three months after completing one or more CALD face to face and online training courses. The CCIA has demonstrated good reliability and adequate construct validity, supported by factor analysis to measure practitioner cultural competence (Doorenbos et al., 2005; University of Auckland, Auckland UniServices Ltd, 2012). In the study, the nine self-assessment items were adapted from the CCAI and modified to enhance their suitability for the target sample and context. Bernhard et al. (2015) highlight the need to further define and adapt existing cultural competence assessment models so that only the most relevant items are used for national target samples and contexts.

2.3 Procedure

All health providers who completed face to face and online CALD Cultural Competency course(s) offered to the Palmerston North, Wellington, Christchurch and Dunedin regions, between 1st March and 30th June 2017 were invited to complete the pre and post training online survey three months after completing the training. The online survey was created using the Patient Experience Reporting System (PERSy), electronic survey software licenced by Waitemata DHB. Participants received an invitation email with a link to the online survey tool. Respondents clicked on the link to complete the online survey. When respondents complete the survey an auto-email was sent to the researchers informing them that a respondent had completed the survey. Learners who did not complete the survey were sent reminders in November and December 2017.

2.4 Data analysis

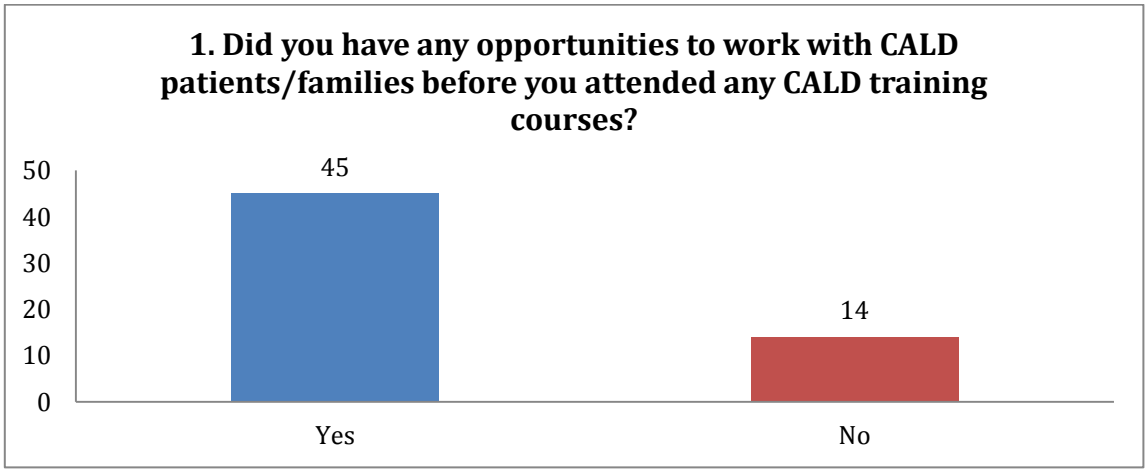
All survey data was collected by the PERSy from the online responses from participants. The PERSy provides statistical analysis of the raw data including graphs of responses to the survey questions. Descriptive statistics were generated to provide a profile of participants. Inferential statistics were conducted to test the significance of differences on the pre-post self-assessment scores on the modified CCAI, and to examine differences in scores as a function of variables: opportunities to work with CALD patients before attending CALD training; how frequently the practitioner engages with CALD patients; opportunities to work with CALD patients after attending CALD training courses; how frequently the practitioner engages with CALD patients post CALD training courses; the number of on-line or face to face CALD courses completed; participants experience of training; and the identification of barriers to the provision of culturally appropriate services. The qualitative data collected by the PERSy from the online responses in Parts C and D were analysed thematically. Section 3.7 discusses the findings of the thematic analysis.

3. Results

3.1 Part A: Experience working with CALD patients/families

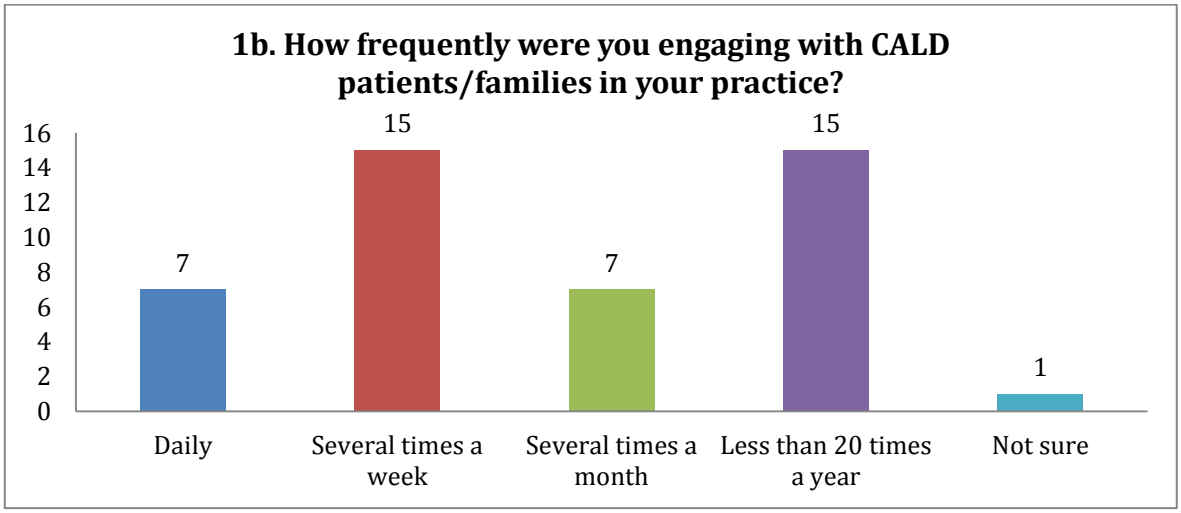
Questions 1 and 1b in Part A investigate the scope of the learners' experience with CALD patients before taking part in the training course. As seen in Figure 1, 45 of the 59 learners, over three quarters of the sample, had worked with CALD patients before attending the training course.

Figure 1: Did you have any opportunities to work with CALD patients/families before you attended any CALD training courses?



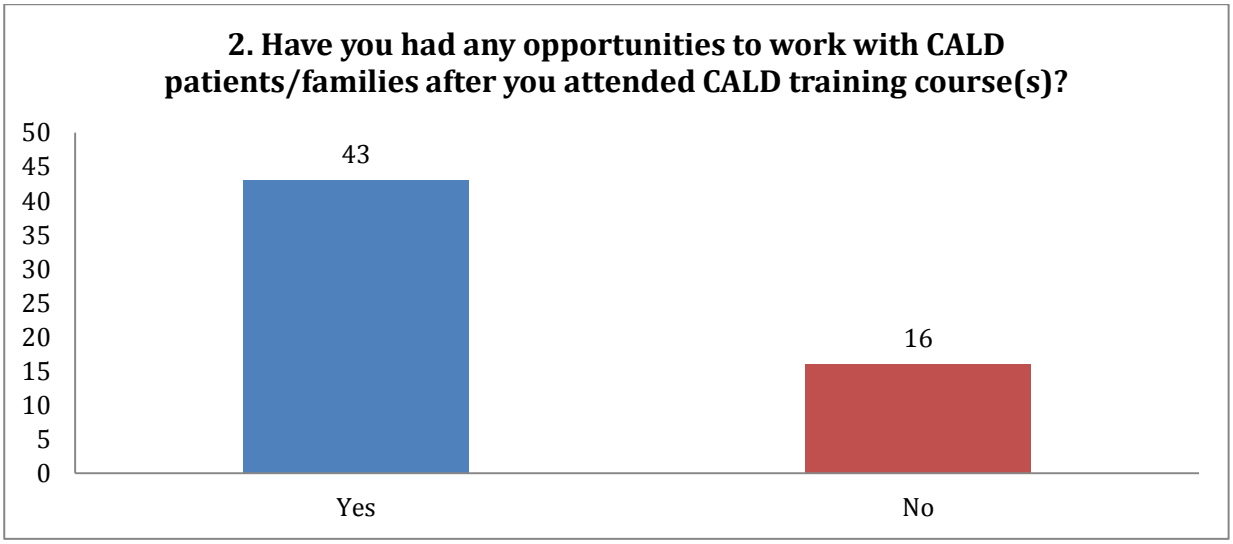
Question 1b examined the frequency of engagement with CALD patients, with responses suggesting that most learners engaged with CALD patients between several times a week and several times a year (M=2.32). The standard deviation of 1.12 indicates the presence of variability in the data, suggesting that the practitioners' experiences with CALD patients vary slightly, but that most of the sample engages with CALD patients fairly regularly. This is shown in Figure 2.

Figure 2: How frequently were you engaging with CALD patients/families in your practice?



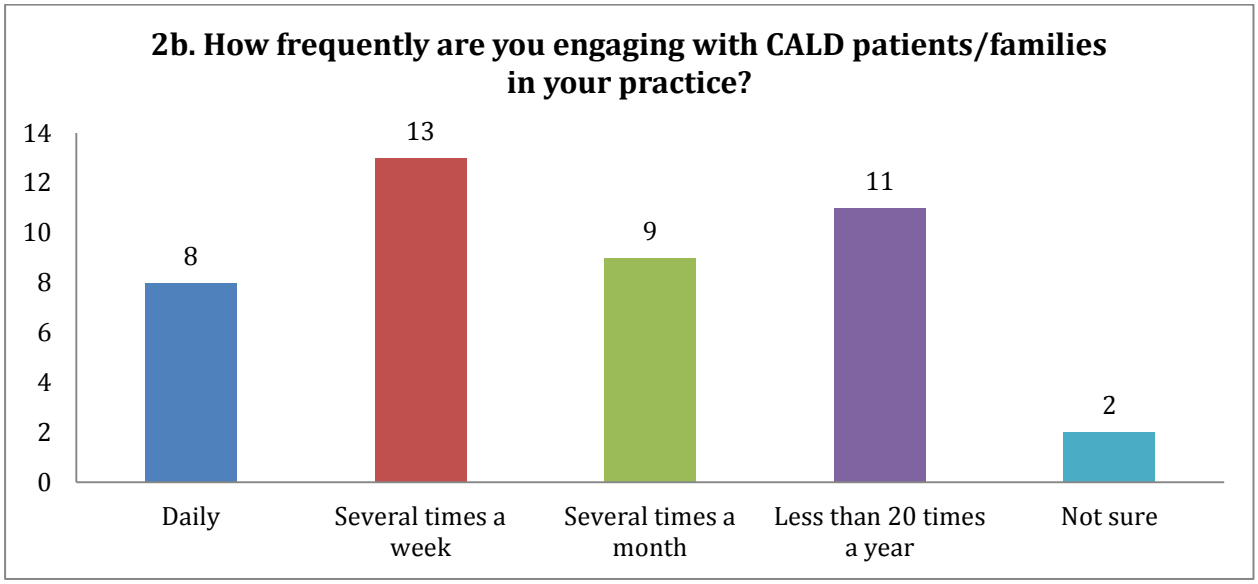
Questions 2 and 2b in Part A investigate how the participants' level of engagement with CALD patients changed after taking part in the training course. Responses to Question 2 show that after taking part in the course(s), 43 of the 59 participants had worked with CALD patients. This result is lower than the number of respondents who had engaged with CALD patients before the training course, but this is most likely to be due to the time frames in question, with Question 1 investigating the full span of their practice before the training course and Question 2 being limited to the time between the training course and the survey (3 months). The responses to Question 2b suggested that more respondents were engaging with CALD patients on a more regular basis (M=2.44). The standard deviation of 1.10 again indicates slight variability in the data, but still suggests that most respondents regularly engage with CALD patients. This is shown in Figure 3.

Figure 3: Have you had any opportunities to work with CALD patients/families after you attended CALD training course(s)?



The responses to Question 2b suggest that more respondents were engaging with CALD patients on a more regular basis (M=2.44). The standard deviation of 1.10 indicates slight variability in the data, but still suggests that most respondents regularly engage with CALD patients. This is shown in Figure 4.

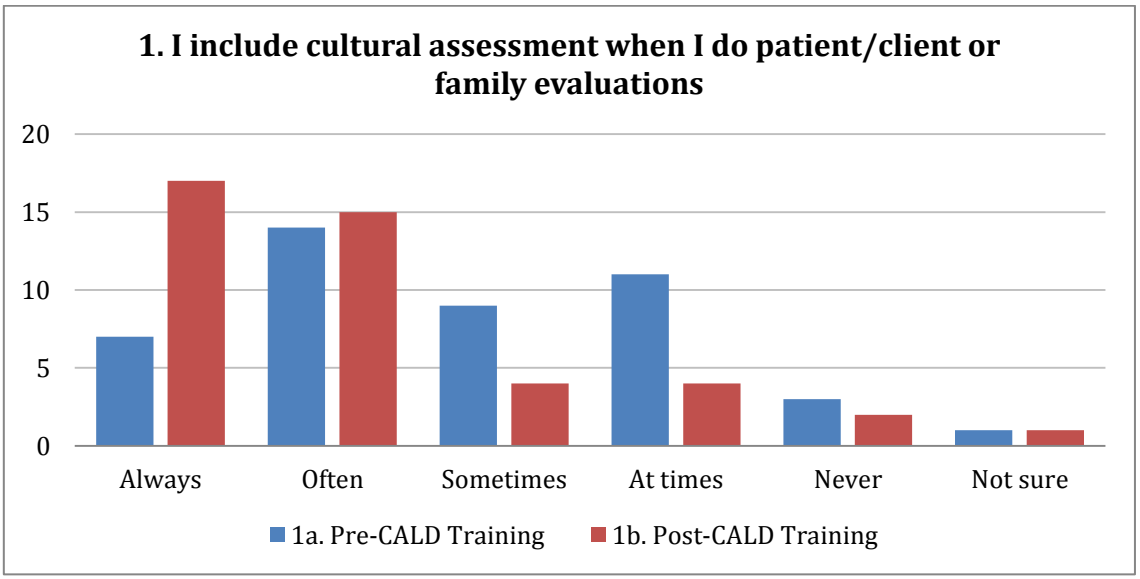
Figure 4: How frequently are you engaging with CALD patients/families in your practice?



3.2 Part B: Application of learned knowledge and skills in practice

Question 1 in Part B asks learners to self-report their use of cultural assessment before and after taking part in the training course. The pre-training responses shown in Figure 5 revealed that although respondents considered cultural assessment, its use was intermittent, with most learners reporting its inclusion "Often" or "At times" (M=3.3). The post-training responses showed an increase in consistent use of cultural assessment, with over 60% of respondents reporting its inclusion "Always" or "Often" (M=4.0).

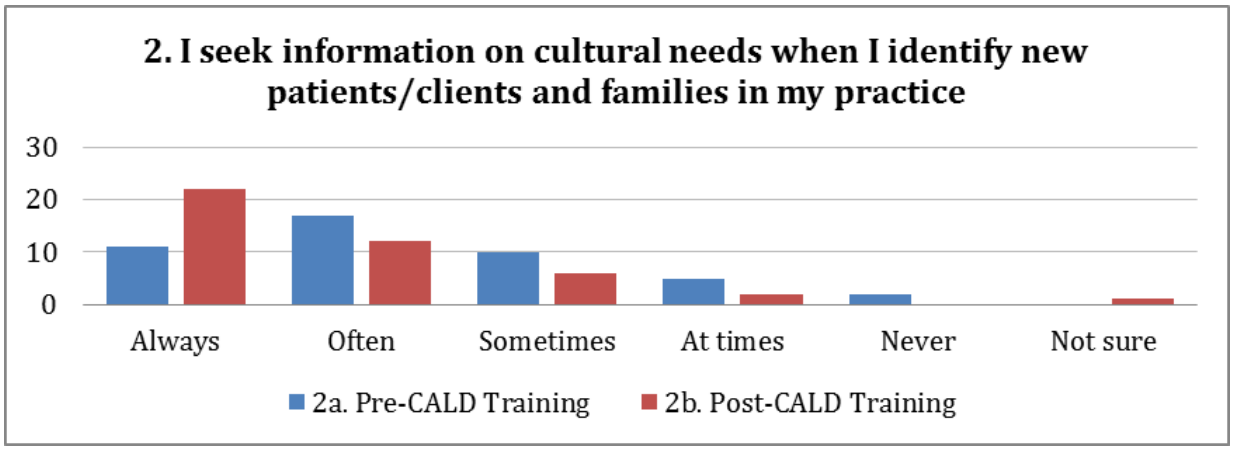
Figure 5: I include cultural assessment when I do patient/client or family evaluations



Question 2 in Part B investigates whether or not learners sought information on cultural needs when identifying new patients in their practice, before and after taking part in the training course. Pre-training, 37.8% of respondents reported "Often" seeking information on cultural needs (M=3.7). However, the spread of variability in responses (as seen in Figure 6) indicates that some respondents rarely or "Never" sought information on cultural needs. After taking part in the training course 51.2% of

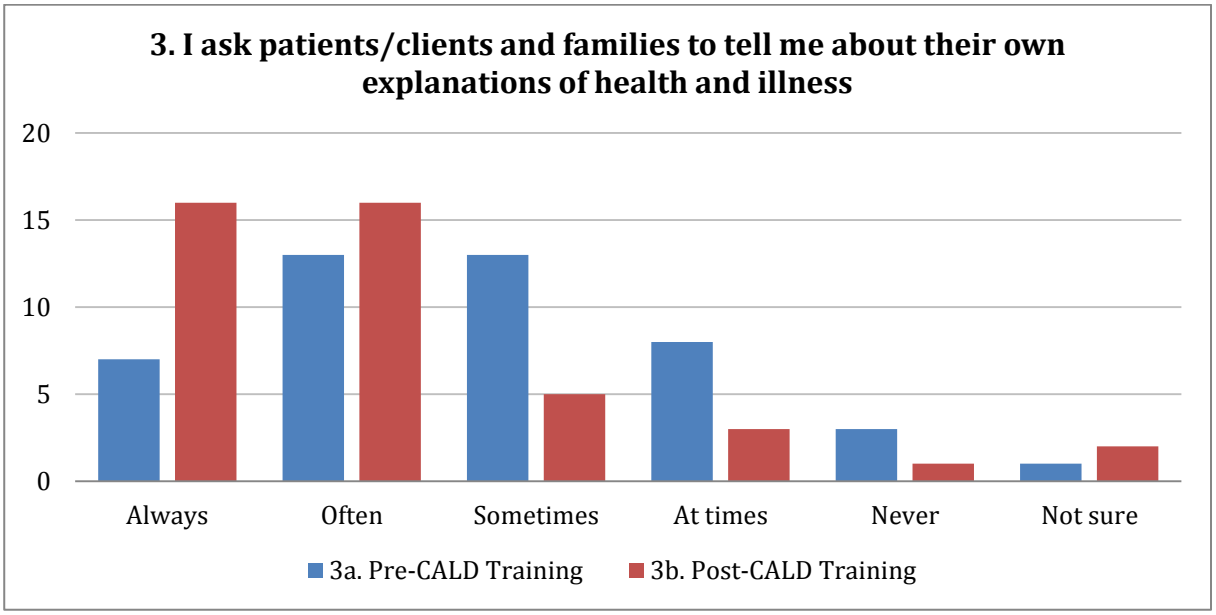
respondents reported “Always” seeking information on cultural needs when identifying new patients, and not a single respondents reported “Never” seeking that information (M=4.3).

Figure 6: I seek information on cultural needs when I identify new patients/clients and families in my practice



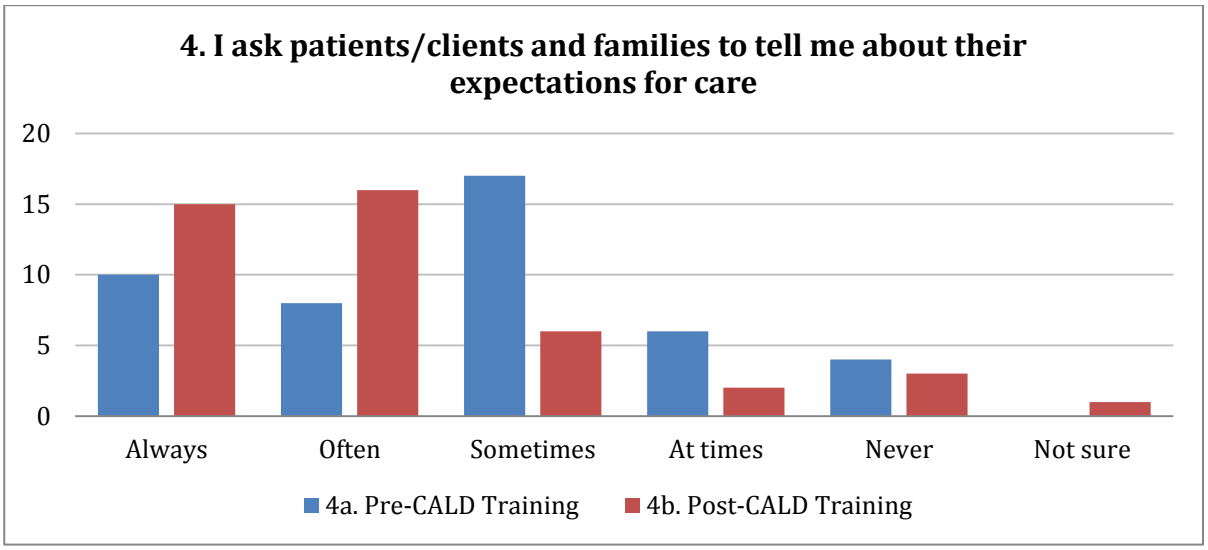
Question 3 in Part B explores the training course’s effect on how often learners encourage patients and their families to report their own explanations of health and illness. Before taking part in the course respondents expressed far more variability in responses, with 6.7% actively “Never” asking patients about their own explanations, and only 15.6% reporting “Always” (M=3.3). After taking part in the training course however, the variability in responses decreased dramatically, with over 70% of respondents reporting “Always” or “Often” asking patients for their own explanations (M=4.0). This is shown in Figure 7.

Figure 7: I ask patients/clients and families to tell me about their own explanations of health and illness



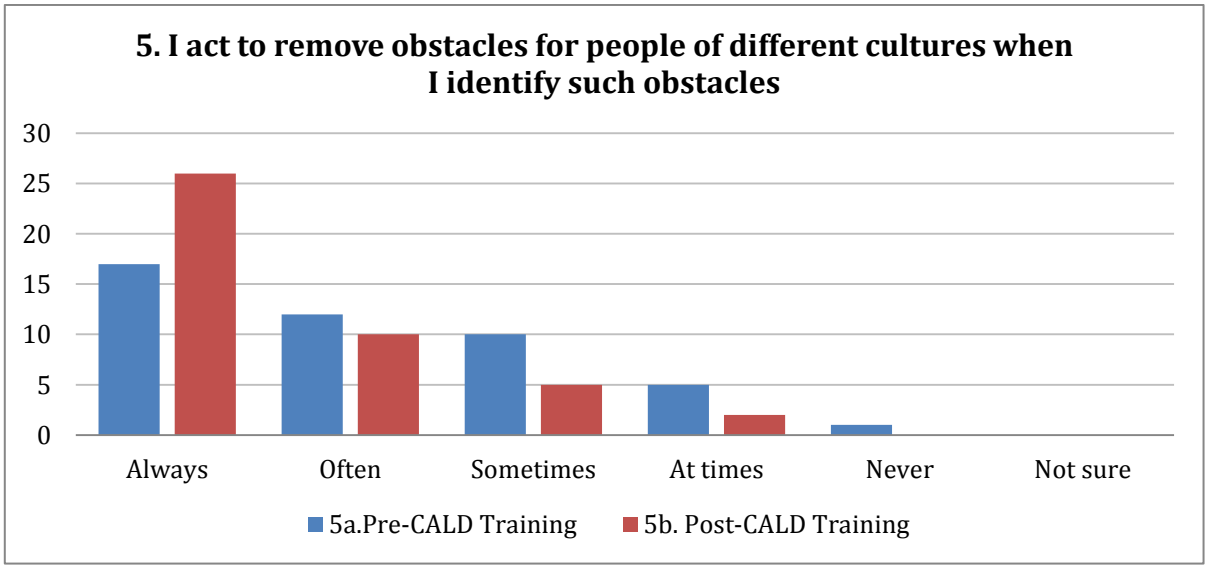
Question 4 in Part B investigates whether taking part in the CALD training course affected how often the learners ask their patients about their own expectations for health-care. Pre-CALD training, respondents' responses were varied with "Sometimes" being the most common response (37.8% of learners, M=3.3). After taking part in the CALD training course, the spread of responses as seen in Figure 8 lean far more towards "Always" and "Often", with 34.9% and 37.2% of respondents respectively (M=3.9).

Figure 8: I ask patients/clients and families to tell me about their expectations for care



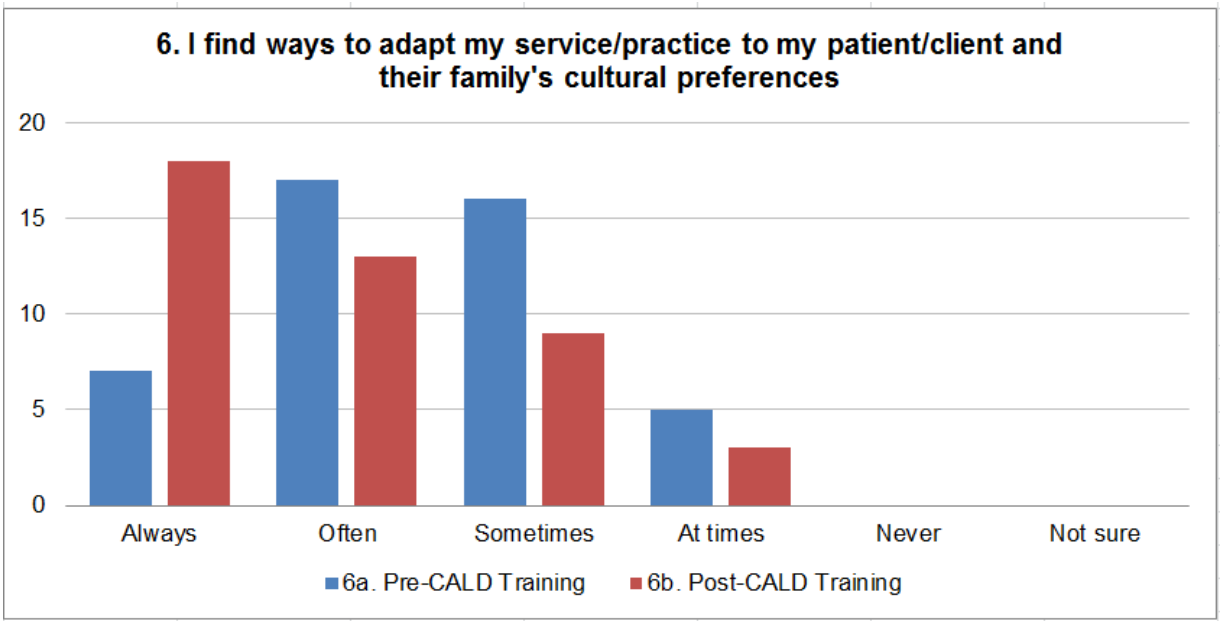
Question 5 in Part B directly asks learners if they act to identify and remove obstacles for people of different cultures, and investigates how the CALD training course affected their responses. Before taking part in the course, as seen in Figure 9, 37.8% of respondents responded "Always" making it the most common response (M=3.9). However, the spread of variability indicates that many respondents were not as consistent in their action against identified obstacles for people of different cultures Post-CALD training, the responses were far less varied, with 60.5% of respondents responding "Always", and not a single respondent responding "Never" (M=4.4).

Figure 9: I act to remove obstacles for people of different cultures when I identify such obstacles



Question 6 in Part B investigates whether the training course affected how often learners find ways to adapt their health practices to their patient's cultural preferences. Before the CALD training, the spread of the respondents' responses focused towards the middle (M=3.6) with most respondents responding "Often" (37.8%) or "Sometimes" (35.6%). After taking part in the CALD training course, the spread of variation in responses, as seen in Figure 10 peaks at "Always" with 41.9% of respondents selecting that response (M=4.1).

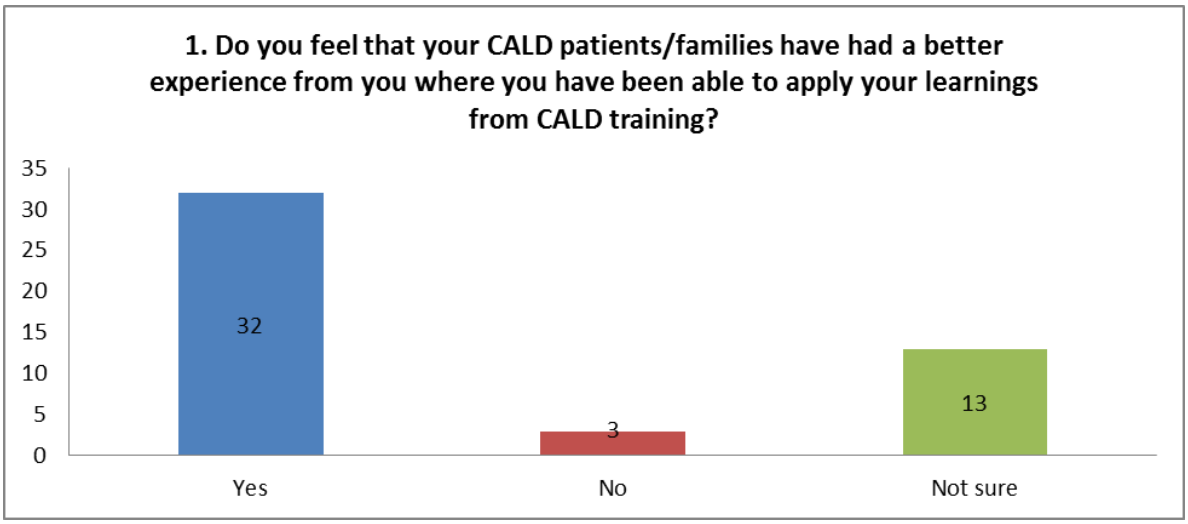
Figure 10: I find ways to adapt my service/practice to my patient/client and their family's cultural preferences



3.3 Part C: CALD patients experiences of your service post training

Question 1 in Part C asks learners to self-report whether or not their CALD patients had benefited from their taking part in the training course. Over 65% of respondents (32 out of a total of 48) responded "Yes", their patients' experiences had improved where they were able to apply their learning from the CALD training. Only three learners reported that the CALD training had not improved the experiences of their patients, suggesting that overall the training course was successful at ensuring better healthcare experiences for CALD patients. This is shown in Figure 11.

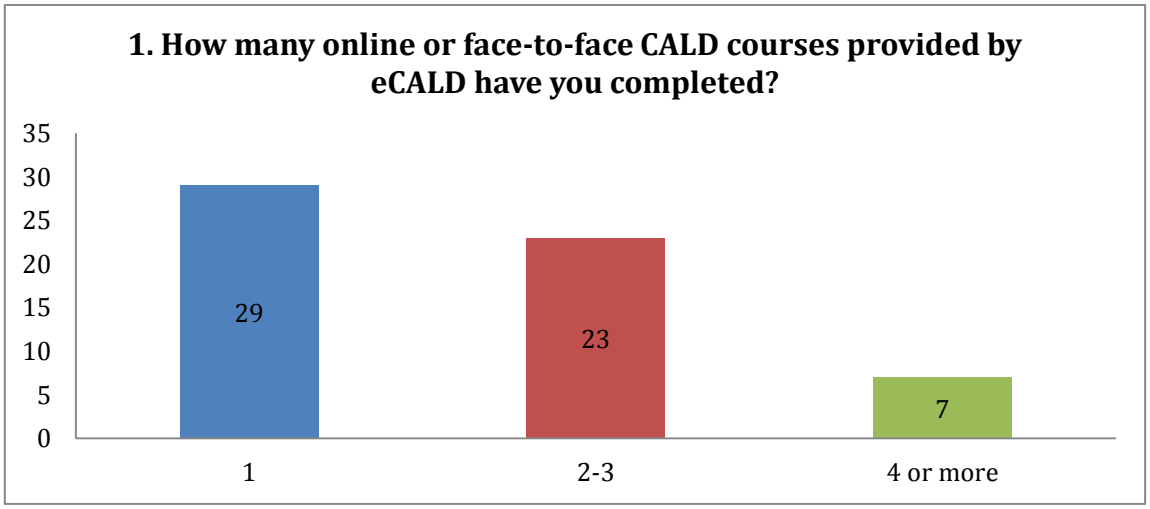
Figure 11: Do you feel that your CALD patients/families have had a better experience from you where you have been able to apply your learnings from CALD training?



3.4 Part D (1): Number of CALD courses completed by learners

Question 1 in Part D investigates how many of the provided CALD courses the learners completed. Out of a total of 59 responses, almost 50% of respondents had completed a single CALD course, with only 7 respondents completing four or more courses.

Figure 12: How many online or face-to-face CALD courses provided by eCALD have you completed?

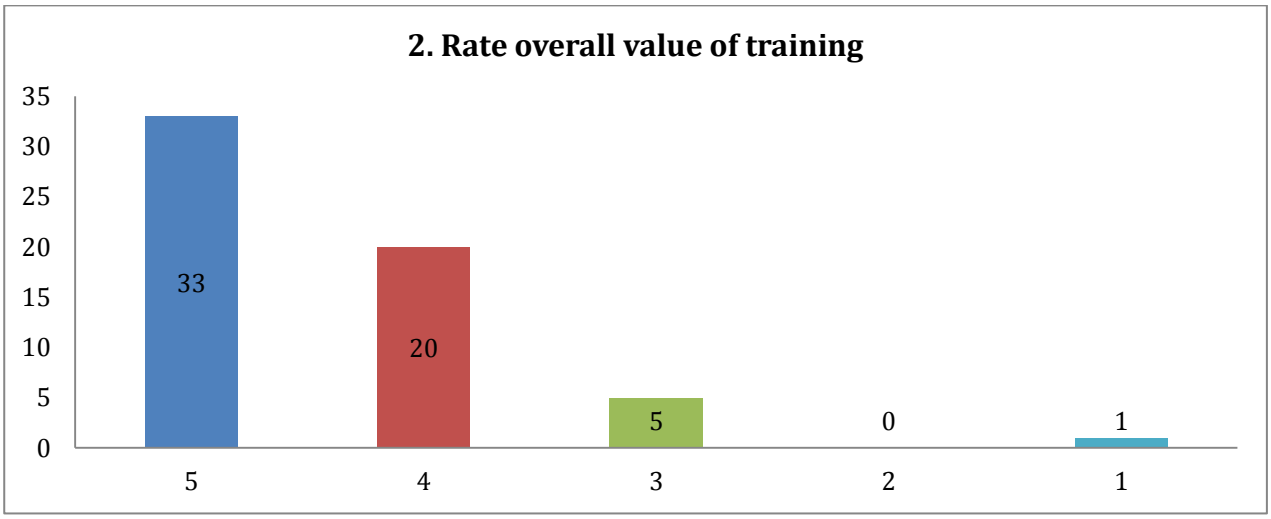


3.5 Part D (2): Overall value of training to participants

Question 2 in Part D asked the learners to self-report their perceived overall value of the CALD training courses. On a rating scale out of 5, over 75% of respondents gave the CALD courses a rating of "4" or above, with over 50% rating it a "5". This suggests that although, as seen from Question 1 in Figure 13,

many of the respondents only completed one or two courses, they found the value of these course(s) immensely useful.

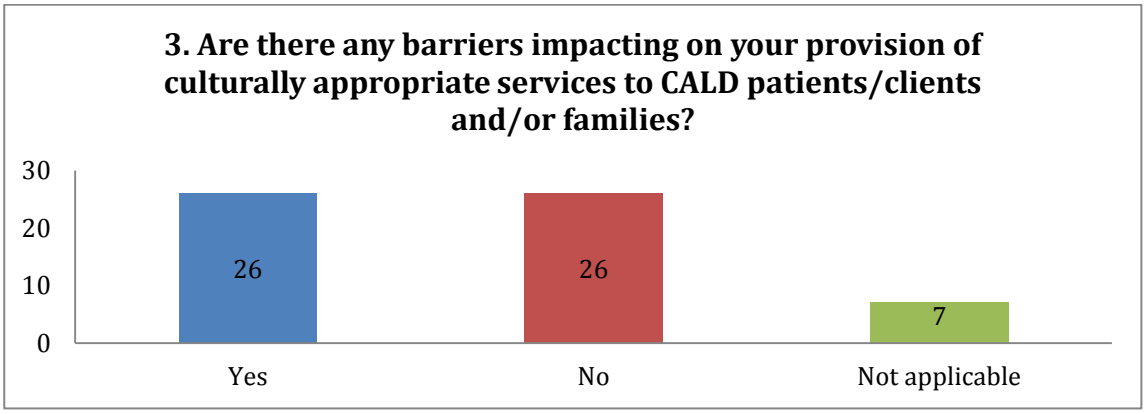
Figure 13: Rate overall value of training



3.6 Part D (3): Barriers to the delivery of culturally appropriate services

Questions 3 and 3b in Part D conclude the post CALD survey by investigating whether the learners had identified any barriers affecting their ability to provide culturally appropriate services to their CALD patients, and then attempting to identify the nature of these barriers. In Question 3, learners are asked merely to report whether or not they believed they were facing barriers affecting their service to CALD patients. The results, as seen in Figure 14, show an equal split between the respondents who responded "Yes", and the respondents who responded "No".

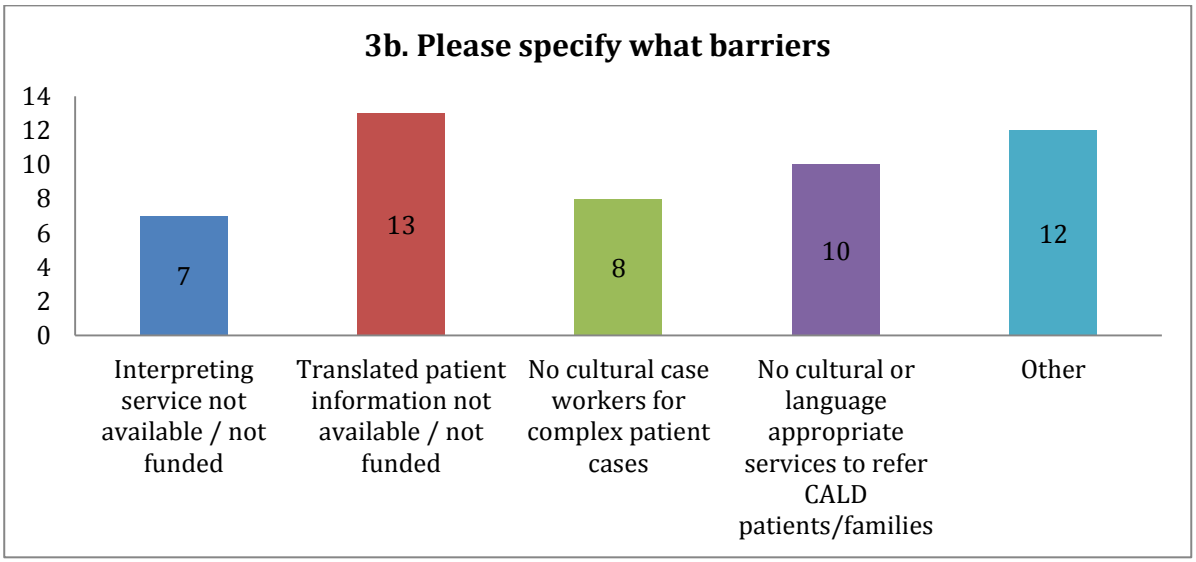
Figure 14: Are there any barriers impacting on your provision of culturally appropriate services to CALD patients/clients and/or families?



Question 3b encouraged the 26 learners who responded "Yes" to Question 3 to specify the kind of barriers they were facing. The most selected response, as seen in Figure 15, was "Translated patient information not available", while the second most selected response was "Other". This suggests that further

investigation should be conducted to gain a better understanding of the types of barriers faced by health practitioners working with CALD patients.

Figure 15: Please specify what barriers



Many authors suggest that in conjunction with cultural competence training for the health workforce, infrastructure and strategies for organisational cultural competency are needed to improve patient outcomes (AHRQ, 2014; Koh et al, 2014; Lie et al., 2010; State of Victoria DHHS, 2016; The Lewin Group, 2002; Truong, 2014). Respondents in the study reported multiple systemic barriers to providing culturally competent care in their region.

3.7 Qualitative Analysis

In Parts C and D respondents were asked to give examples of how they had applied what they had learned from CALD cultural competency training in practice and whether patients had as a result had a better experiences of care. Additionally, health practitioners were asked to identify the barriers they encountered to providing culturally appropriate services to CALD patients and families in greater detail.

Question 1B in Part C asked "Do you feel that your CALD patients/families have had a better experience from you where you have been able to apply your learnings from CALD training?" Respondents were asked for examples, from which four themes emerged: Engaging with clients and families; using interpreters; cultural awareness; and asking questions, understanding cultural needs and responding. These are discussed in this section.

1. Engaging clients and families

The two most commonly mentioned areas of applying new learnings were in engaging with families and in using interpreters. For example one respondent stated that:

"I am now more aware of the initial meeting and asking them how they want to be addressed and to make sure I have an awareness of the culture and the 'hierarchy' within the culture who do you address and how". Another said, "[I have] better awareness of cultural issues such as: Appropriate introduction and checking acceptable ways of addressing patients, including significant others in consultation. [Understanding] attitudes to authority and advice".

Another respondent post training now, “offered time to discuss with significant others. Shared a greeting in their language and asked how best to pronounce their name. Clarified their needs and expectations”.

2. Using interpreters

Typically, respondents stated that:

“being able to use interpreters has made a huge difference” and that they were making, “more professional use of interpreters. More checking with family understanding and perceptions of [the] consultation”.

Post training, respondents would now “wait until the interpreter has arrived in clinic rather than start with a family member to interpret”.

3. Cultural awareness:

Respondents indicated that they were now more culturally aware of their patient’s migrant and refugee journeys; and their settlement challenges in New Zealand society. For example, one health practitioner said:

“I am more focused on what it is that the patient already understands and more particularly what it is that they want in the future. I am more aware of some of the barriers to health care and go outside the usual box to facilitate access to the service I am involved with. I am more aware of the journey and experience that they are going through”.

Importantly, practitioners were more aware of the impact of the refugee experience on client’s which had altered their perceptions of their presentations and the labelling of behaviours. For example, one health practitioner stated:

“My current awareness of the possible trauma, horrible experiences, and bad experiences with authorities make me more understanding, and less likely to pathologise clients post training”.

The following example showed increased cultural sensitivity around gender issues:

“I asked an elderly Afghani woman, through her daughter-in-law, whether or not she minded a male pharmacy student asking her some questions about her medicines. She objected and did not want to interact with a man. I would not have thought to ask about her preferences before CALD training”.

4. Asking questions, understanding cultural needs and responding

There was evidence that practitioners were putting the new cross- cultural skills they had learned into practice. The following are some examples health practitioners gave of changes in their practice:

“I am more aware of cultural identity and more adaptive in how and what I do. I am prepared to take my time as communication takes longer”.

“The hot patient bedroom - hot food - hot fluids thing all makes sense now. The mother-in-law in the room with new mother dynamic. The head nodding agreement to everything you say etc etc”

“Gaining a better understanding of the importance of all peoples cultural needs has allowed me to incorporate this into my practice”.

"I work in a Women's health setting and I feel after the training I am more aware of the different cultural needs and I try to work in a sensitive and respectful way to support the women through an often stressful time".

In Part D, Question 3b asked "Are there any barriers impacting on your provision of culturally appropriate services to CALD patients/clients and/or families, eg language barriers, etc?". Respondents were asked to specify these barriers. The time factor was the most commonly cited barrier to providing culturally appropriate services. Typically, respondents stated "not enough time available". Some found solutions such as the following respondent who worked in a:

"Very busy outpatient department with time constraints. [I] can make a double booking at times to accommodate this".

The next most commonly mentioned barrier was organisational buy-in to the need for culturally competent services. One respondent commented that there was a:
"need to develop organisational capabilities at all levels (including frontline) to better deal with CALD customers".
Another stated that the "rest of maternity ward staff have not embraced eCALD courses".

Additional barriers included: clients finding their way to services and appointments; trusting New Zealand health practitioners and following through; and limited access to interpreting services. This was summed up by one respondent who said:

"Ability to physically access services at the hospital - parking is just so hard. Knowing where to go and being able to find where the appointment is. Gaining trust with New Zealand health care workers. Language and cultural gaps in understanding".

4. Discussion

The survey provides clear evidence that CALD learner's attitudes and behaviours when working with CALD refugee patients and families were improved and as well, that post training there was a perceived improvement in patient experience. The post-training responses showed an increase in respondents' consistent use of cultural assessment, with over 60% of respondents reporting its inclusion "Always" or "Often".

The CALD training was useful in improving Learner's cross-cultural practice. Respondents' post-training responses showed an increase in the consistent use of cultural assessment, with over 60% of respondents reporting its inclusion as "Always" or "Often". After taking part in CALD training 51.2% of respondents reported that they "Always" sought information on cultural needs when identifying new patients and not a single participant reported "Never" seeking that information. This finding indicates that participating in CALD training improved learners' confidence, knowledge and skills in seeking information on patient's cultural needs. Post training there was a dramatic increase, over 70% of respondents reported "Always" or "Often" asking patients and families for their explanations of health and illness. Pre training respondents expressed far more variability in responses, with 6.7% actively "Never" asking patients about their own explanations, and only 15.6% reporting "Always". There was improvement as well in whether respondents asked their patients about their expectations for health-care, with more "Always" and "Often" responses post training.

Respondents also improved their patient advocacy and assisted patients with navigating the health system more frequently post training (60.5% reported “Always” cf 37.8% pre- training). After taking part in the CALD training course, more respondents found ways to adapt their health practices to their patient’s cultural preferences than were able to pre-training. In response to the survey question asking learners whether or not their CALD patients had benefited from their taking part in the training course. Over 65% of respondents responded “Yes”, their patients’ experiences had improved where they were able to apply their learning from the CALD training.

Respondents found the CALD training of high value. On a rating scale out of five, over 75% of respondents gave the CALD courses a rating of “4” or above, with over 50% rating it a “5”. This suggests that although many of the respondents only completed one or two courses, they found the value of these courses immensely useful.

As well as assessing whether Learners had improved their cross-cultural skills and if this had led to improved patient experience, a further aim was to investigate whether learners had identified any barriers affecting their ability to provide culturally appropriate services to their CALD patients, and the nature of these barriers. Fifty per cent of respondents answered “Yes”. The most selected barriers identified were: “Translated patient information not available”, while the second most selected response was “Other”. This latter finding suggests that further investigation is needed to gain a better understanding of the types of barriers faced by health practitioners working with CALD patients.

Strengths and limitations of study

The strength of the study is that it explicitly links eCALD training with the improved ability of practitioners to provide culturally competent care, and to advocate for culturally competent services on behalf of CALD patients.

Importantly, the study shows that CALD Cultural Competency training as a standalone strategy is inadequate to improve patient outcomes. Concurrent systemic and organisational changes such as the availability of professional interpreters, translated patient education and information, refugee community health workers and cultural caseworkers as part of the health care team are needed to optimise the impact of professional development. In addition to health practitioner cultural competency education and training, changing the clinical environment can also be key to purposeful change in behaviour. For example, a focus on organisational cultural competence standards rather than a singular focus on the patient/provider relationship. The study supports the view in the international literature that changes in provider knowledge attitudes and skills is a necessary step, but for those gains to translate into culturally competent behaviours there also needs to be a change in the infrastructures, strategies and culture of the health care system and organisations to include ethnic populations in planning and service delivery design (Koh, 2014; State of Victoria DHHS, 2016; The Lewin Group, 2002).

The limitations of the study include the small sample size. We invited 281 participants to participate in the Pre and Post Online Training Online Survey and of these 100 were unable to be contacted due to emails returned undelivered. Out of 181 successfully sent invitations we received 59 (32.6 %) responses to the survey. A further limitation was the short duration of the intervention period. Almost half of the respondents had only completed a single CALD course. Self-report studies are subjective and may potentially be biased by the Learners perceptions of their knowledge and skills and of their patients’ experience post training. It is possible that respondents overestimated the effectiveness of the CALD training. The generalisability of the findings is limited to the communities under study (Palmerston North, Wellington, Christchurch and Dunedin) and these settings are individually unique.

The results of this study support the findings of New Zealand and international literature on the effectiveness of CALD cultural competency training in improving health practitioner's knowledge, attitudes and behaviours when working with culturally diverse patients and families (Lie et al., 2010; Renzaho et al., 2013; Truong et al., 2014). An independent evaluation of the WDHB CALD Training Course conducted by the University of Auckland found similarly that completion of CALD 1 training had a significant impact on participant's cultural competency (University of Auckland, Auckland UniServices Ltd, 2012).

Participants in the study conducted in Auckland found CALD 1 to provide many useful aspects with respect to increasing their cultural competency and described various ways in which they had utilised learning in practice (University of Auckland, Auckland UniServices Ltd, 2012). They reported increased knowledge of cultural differences, including values, health beliefs, religious beliefs, gestures and customs, and better skills when interacting and communicating with CALD patients. They also described ways in which their awareness of and sensitivity towards CALD patients had been enhanced. Moreover, according to the qualitative evidence obtained, participants in CALD Module 1 reported a heightened awareness of their own culture and how their own cultural beliefs impacted on how they viewed other cultures different from their own.

Participants' experience of CALD Module 1 was overwhelmingly positive. They reported high levels of satisfaction with the content, programme delivery and quality of resources. The authors reported that the CALD Module 1 achieved the aims of delivering a high quality, well designed, interactive, engaging, educational and self-reflective programme, with good quality video scenarios, offering mixed learning options that enhanced learning (University of Auckland, Auckland UniServices Ltd, 2012).

5. Conclusion

The study found evidence of improvement in health providers' cross-cultural practice and patient experience. The study findings highlight the need not only to improve culturally competent care at the practitioner-patient level, but also at the organisational and systemic-levels. Organisational culture can affect the implementation and success of interventions to improve culturally competent practice. Cultural competency interventions are multi-dimensional in nature and the development of CALD organisational cultural competency models in New Zealand health services is needed.

The study included the explicit incorporation of the perspectives of health care providers on barriers to the provision of culturally appropriate services for CALD clients and their families. This approach ensured that the study covered the systemic and organisational barriers which prevent the delivery of culturally competent care. These barriers include: the unavailability of professional interpreting services; no translated patient information available in the languages of the refugee populations served; no cultural case workers available to support practitioners and CALD patients in the communities under study.

6. Terms used and glossary

The following are a list of terms used in this document:

Term	Definition
Asian	People originating from Asian countries including countries in West Asia (Afghanistan and Nepal), South Asia (covering the Indian sub-continent), East Asia (covering China, North and South Korea, Taiwan, Hong Kong and Japan) and South East Asia (Singapore, Malaysia, the Philippines, Vietnam, Thailand, Myanmar, Laos and Cambodia). This definition is commonly used within the health sector and is the basis of Statistics New Zealand Asian ethnicity categories.
CALD	Culturally and Linguistically Diverse
Clients	Clients/Patients or families refers to refugee clients/patients and families
CME/CNE/MOPS	Clinical Medical Education; Clinical Nursing Education; Maintenance of Professional Standards Programme • Doctors in New Zealand have a requirement to participate in CME and practice review activities as part of their Maintenance of Professional Standards Programme (MOPS) • Nurses in New Zealand, as part of the requirements of the Health Practitioners Competency Assurance Act, must participate in cultural competency training
EQR	Emergency Quota Refugees
Health provider, practitioner, clinicians, practitioner, health professional, health providers	Roles in health, mental health and disability services providing healthcare services.
Learners	Learners refers to health professionals who have completed the CALD courses
MELAA groups	Middle Eastern, Latin American and African groups.
Migrants	People who were born overseas who settle in New Zealand (also known as immigrants).
Patients	Clients/Patients or families refers to refugee clients/patients and families
Refugees	In this resource, refugees refer to people who arrive in New Zealand under one of three categories: • Quota refugees • Family reunification members • Asylum seekers
The Training	Culturally and Linguistically Diverse (CALD) Cultural Competency Training

Glossary

The following are a glossary of abbreviated terms used in this document:

Abbreviation	Description
CALD	Culturally and Linguistically Diverse
CCAI	Cultural Competency Assessment Instrument
DHB	District Health Board
EQR	Emergency Quota Refugees
GP	General Practitioner
HPCAA	Health Practitioners Competence Assurance Act, 2003
Immigration NZ	Immigration New Zealand is a branch of the Ministry of Business, Innovation and Employment (MBIE)
MELAA	Middle Eastern, Latin American, and African
MOH	Ministry of Health
NGO	Non-governmental organization
NZ	New Zealand
NZ Red Cross Refugee Resettlement Services	New Zealand Red Cross Refugee Resettlement Services are contracted by Immigration New Zealand to provide settlement support in the community over the first 12 months. This includes an orientation programme and connecting refugees to services they require such as doctor's appointments, English language, education and employment.
PHO	Primary Health Organisation
WDHB	Waitemata DHB

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8. Appendices

Appendix 1:

Pre and Post CALD Training Online Survey Form

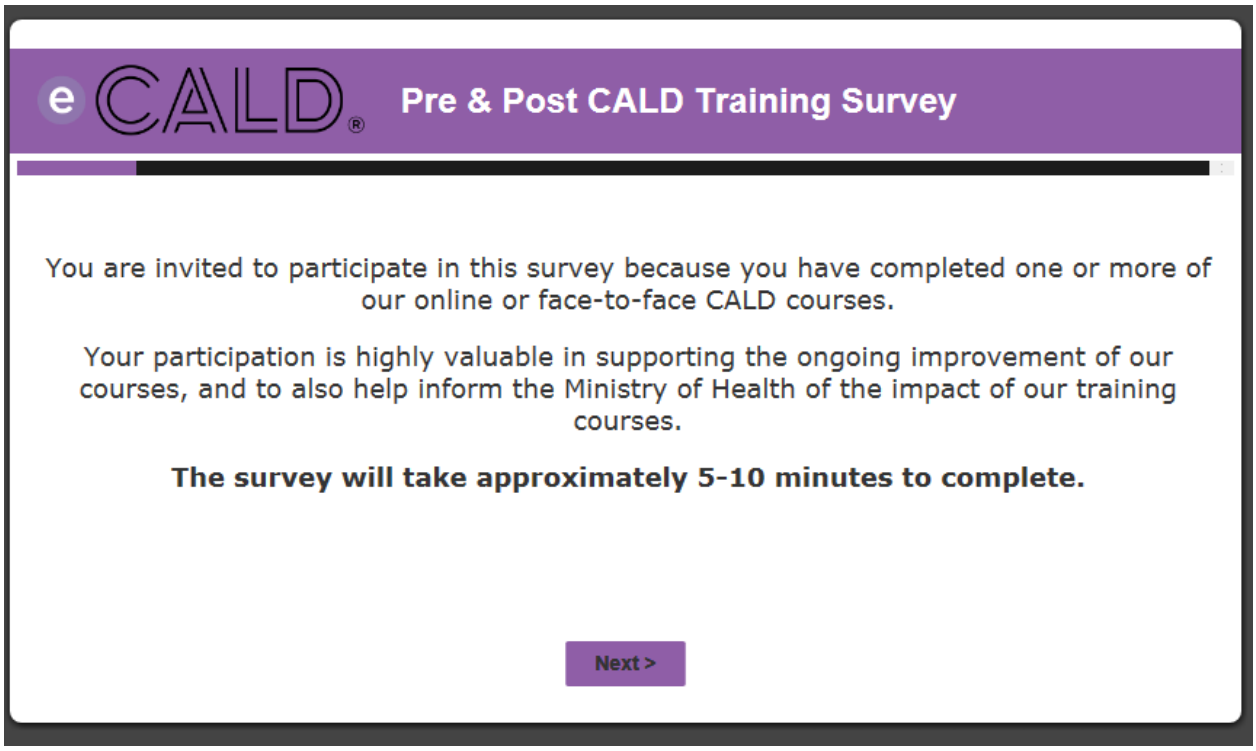
You are invited to participate in this online survey because you have completed one or more of the CALD Cultural Competency face-to-face courses (delivered by eCALD® Services) which was organized and promoted by learning & development or the course coordinators in your region (Dunedin, Invercargill, Wellington, Porirua, Wairarapa, Palmerston North, Canterbury).

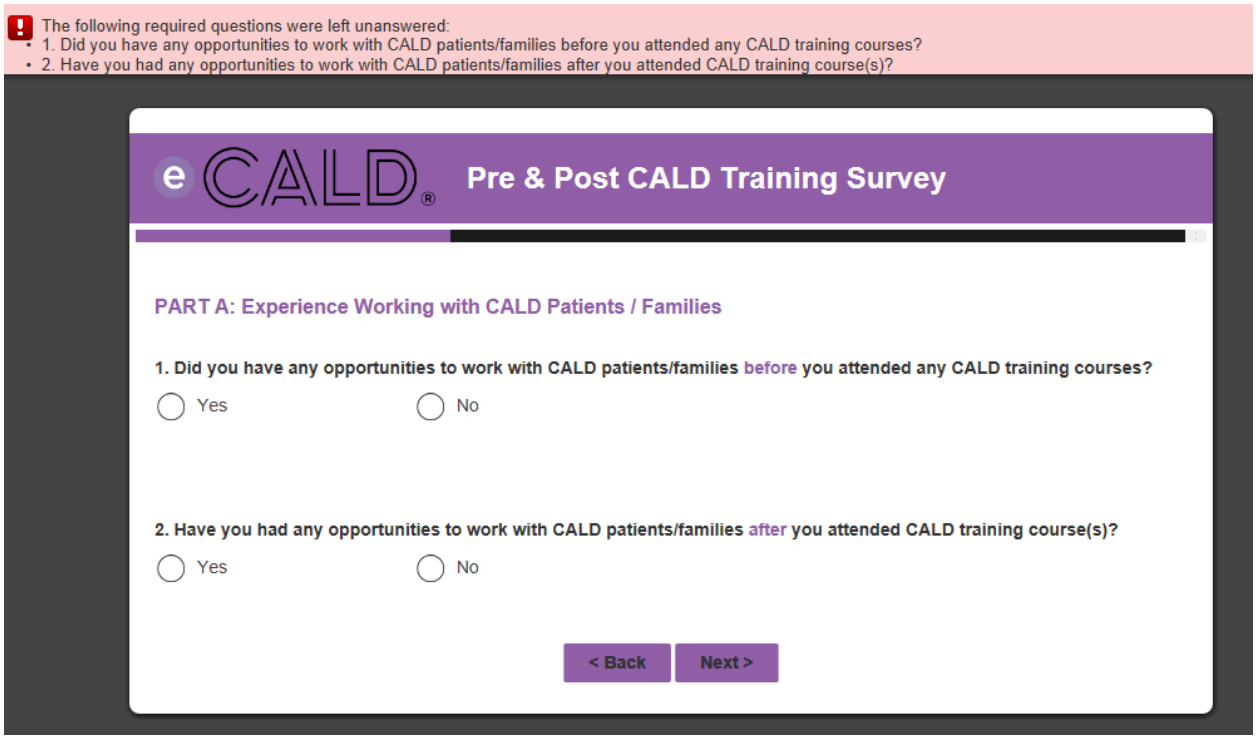
As the CALD training provider we have been asked by the funder (Ministry of Health) to conduct a survey to ascertain the impact of the training on attitude and behavioural changes of learners, learners' experience of the training, CALD patient experience of your service after the training, and also to explore potential or system barriers that impact on your provision of culturally appropriate services to CALD patients/families. The questionnaire will take approximately 5-10 minutes to complete.

Your participation is highly valuable in informing improvements to course content and to help us inform the Ministry of Health of the impact of the training.

Submission deadline: 31st December 2017
NB: If you wish to provide your name and email to us at the end of the survey, we will enter your name into a prize draw that will be announced on 15th January 2018. We have 3 x $50 movie vouchers to be won.

PRE & POST CALD TRAINING SURVEY QUESTIONS
***ALL QUESTIONS ARE MANDATORY**




The following required questions were left unanswered:
1. Did you have any opportunities to work with CALD patients/families before you attended any CALD training courses?
2. Have you had any opportunities to work with CALD patients/families after you attended CALD training course(s)?
eCALD®
Pre & Post CALD Training Survey
PART A: Experience Working with CALD Patients / Families
1. Did you have any opportunities to work with CALD patients/families before you attended any CALD training courses?
Yes
No
2. Have you had any opportunities to work with CALD patients/families after you attended CALD training course(s)?
Yes
No
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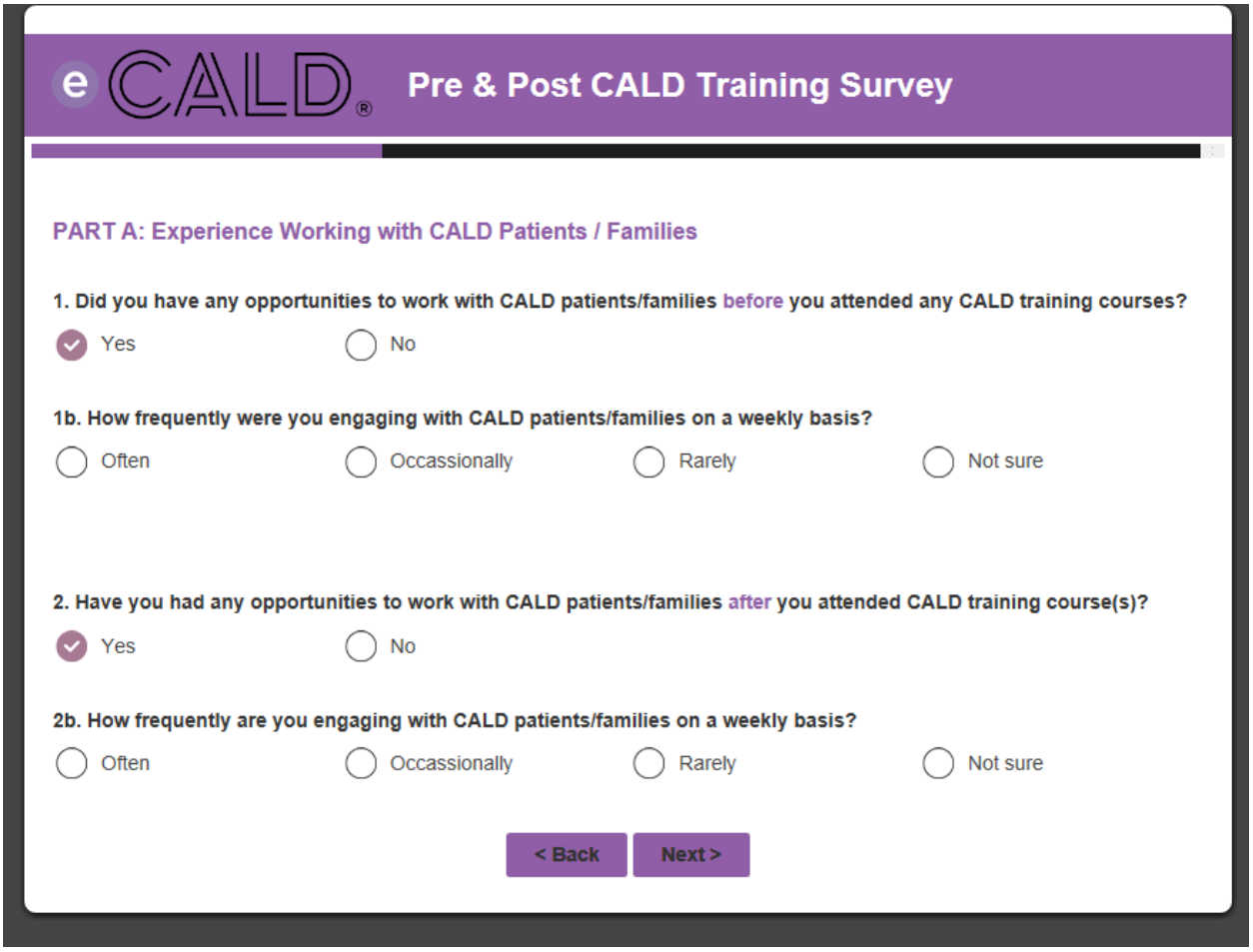
eCALD®
Pre & Post CALD Training Survey
PART A: Experience Working with CALD Patients / Families
1. Did you have any opportunities to work with CALD patients/families before you attended any CALD training courses?
Yes
No
1b. How frequently were you engaging with CALD patients/families on a weekly basis?
Often
Occassionally
Rarely
Not sure
2. Have you had any opportunities to work with CALD patients/families after you attended CALD training course(s)?
Yes
No
2b. How frequently are you engaging with CALD patients/families on a weekly basis?
Often
Occassionally
Rarely
Not sure
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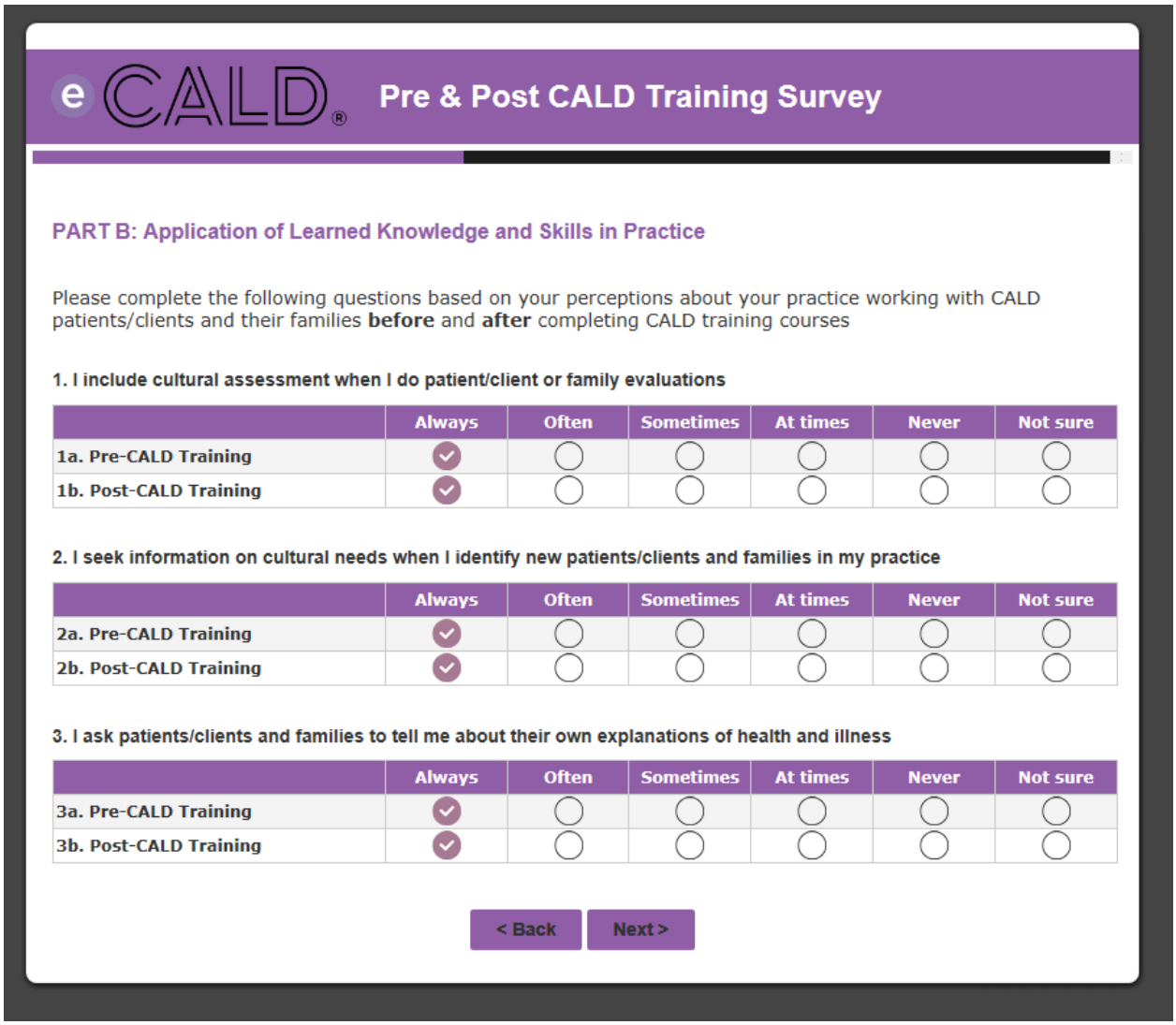
eCALD®
Pre & Post CALD Training Survey
PART B: Application of Learned Knowledge and Skills in Practice
Please complete the following questions based on your perceptions about your practice working with CALD patients/clients and their families before and after completing CALD training courses
1. I include cultural assessment when I do patient/client or family evaluations
Always Often Sometimes At times Never Not sure
1a. Pre-CALD Training
1b. Post-CALD Training
2. I seek information on cultural needs when I identify new patients/clients and families in my practice
Always Often Sometimes At times Never Not sure
2a. Pre-CALD Training
2b. Post-CALD Training
3. I ask patients/clients and families to tell me about their own explanations of health and illness
Always Often Sometimes At times Never Not sure
3a. Pre-CALD Training
3b. Post-CALD Training
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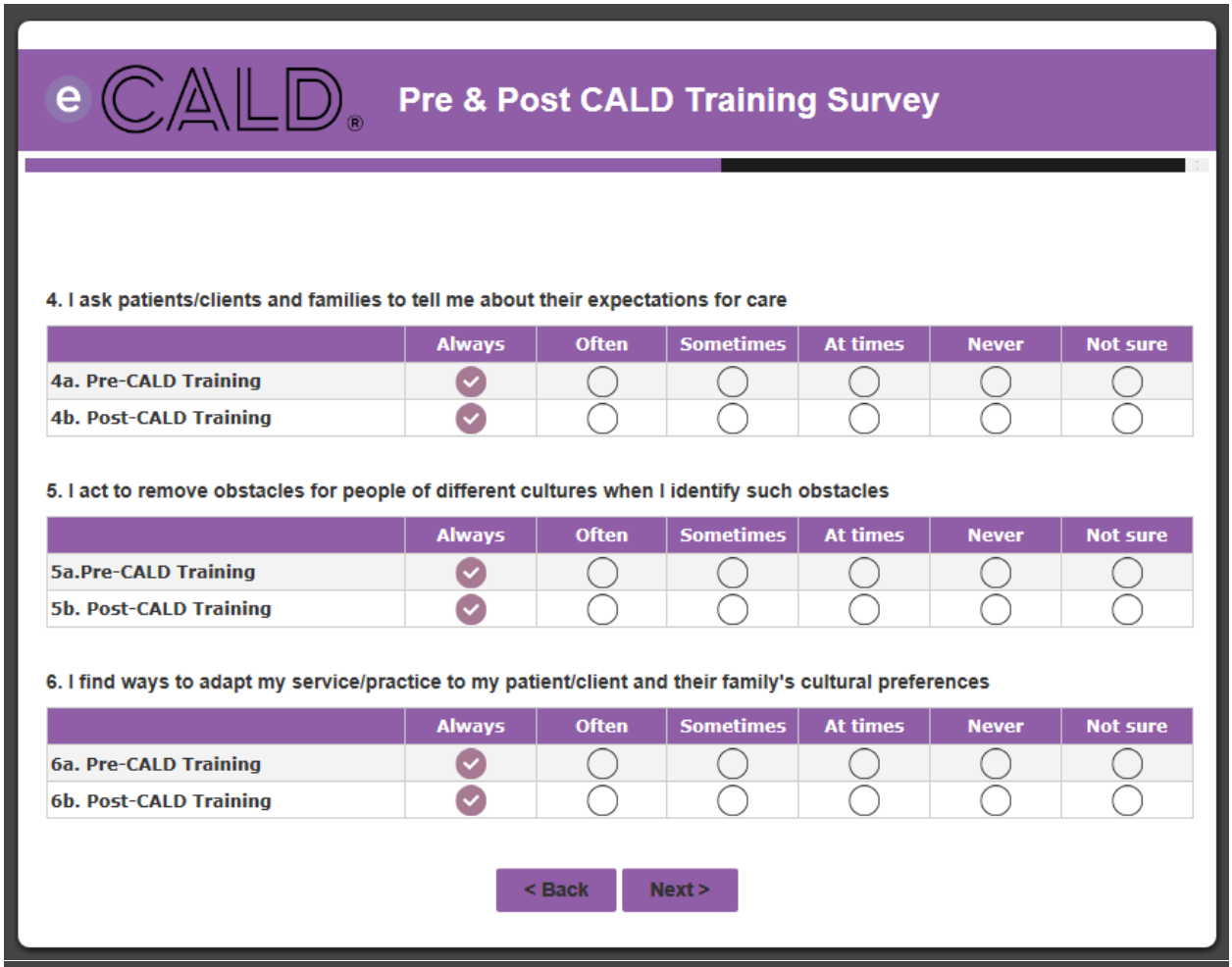
eCALD®
Pre & Post CALD Training Survey
4. I ask patients/clients and families to tell me about their expectations for care
Always
Often
Sometimes
At times
Never
Not sure
4a. Pre-CALD Training
4b. Post-CALD Training
5. I act to remove obstacles for people of different cultures when I identify such obstacles
5a.Pre-CALD Training
5b. Post-CALD Training
6. I find ways to adapt my service/practice to my patient/client and their family's cultural preferences
6a. Pre-CALD Training
6b. Post-CALD Training
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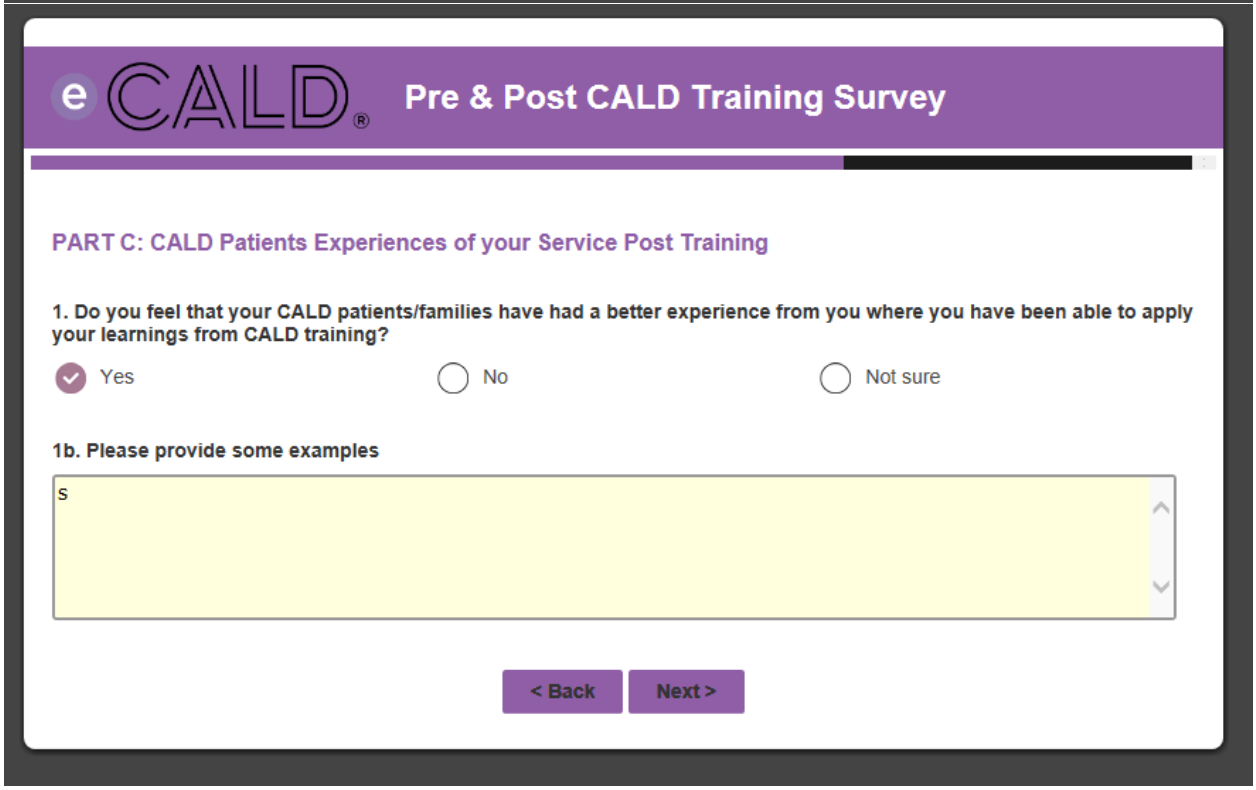
eCALD®
Pre & Post CALD Training Survey
PART C: CALD Patients Experiences of your Service Post Training
1. Do you feel that your CALD patients/families have had a better experience from you where you have been able to apply your learnings from CALD training?
Yes
No
Not sure
1b. Please provide some examples
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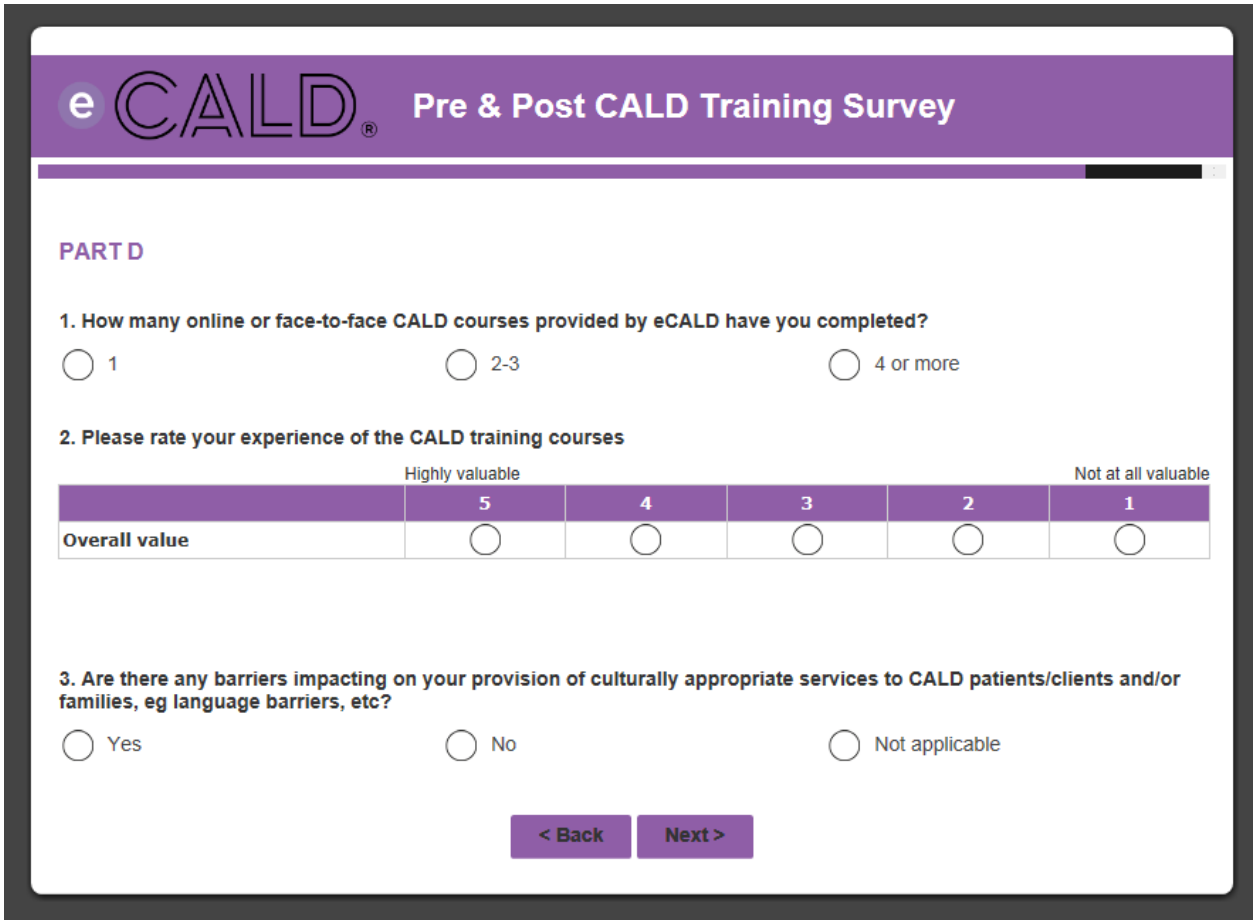
eCALD®
Pre & Post CALD Training Survey
PART D
1. How many online or face-to-face CALD courses provided by eCALD have you completed?
1
2-3
4 or more
2. Please rate your experience of the CALD training courses
Highly valuable
Not at all valuable
5
4
3
2
1
Overall value
3. Are there any barriers impacting on your provision of culturally appropriate services to CALD patients/clients and/or families, eg language barriers, etc?
Yes
No
Not applicable
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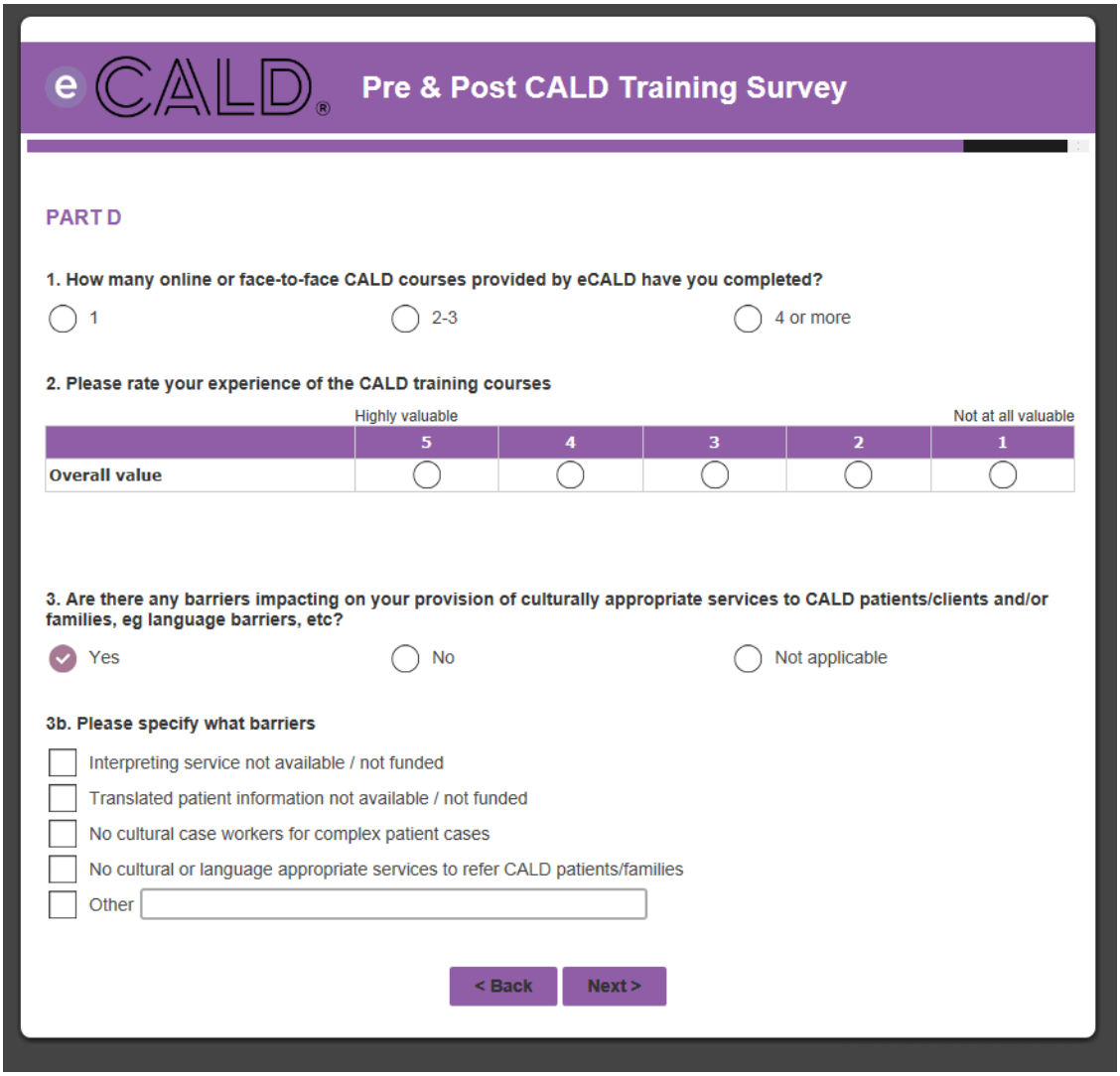
eCALD®
Pre & Post CALD Training Survey
PART D
1. How many online or face-to-face CALD courses provided by eCALD have you completed?
1
2-3
4 or more
2. Please rate your experience of the CALD training courses
Highly valuable
Not at all valuable
5
4
3
2
1
Overall value
3. Are there any barriers impacting on your provision of culturally appropriate services to CALD patients/clients and/or families, eg language barriers, etc?
Yes
No
Not applicable
3b. Please specify what barriers
Interpreting service not available / not funded
Translated patient information not available / not funded
No cultural case workers for complex patient cases
No cultural or language appropriate services to refer CALD patients/families
Other
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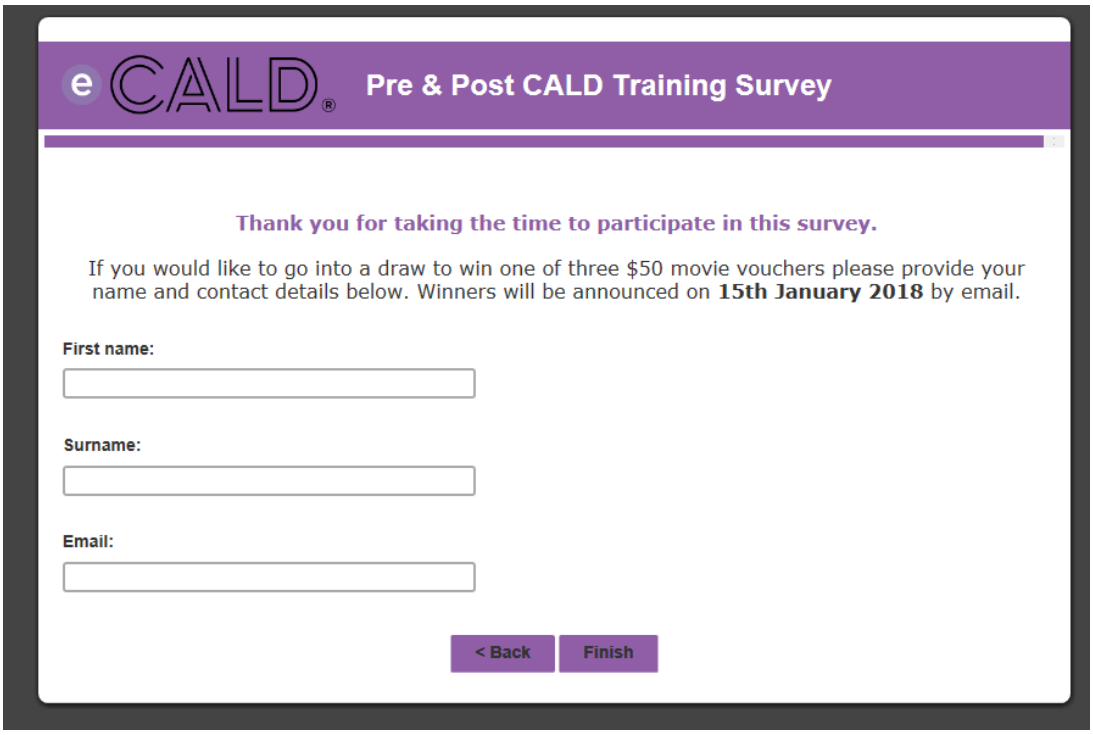
eCALD®
Pre & Post CALD Training Survey
Thank you for taking the time to participate in this survey.
If you would like to go into a draw to win one of three $50 movie vouchers please provide your name and contact details below. Winners will be announced on 15th January 2018 by email.
First name:
Surname:
Email:
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Finish