‘This is the peer reviewed version of the following article:
Muir-Cochrane, E., O’Kane, D., McAllister, M., Levett-Jones, T. and Gerace, A. (2017), Reshaping curricula:
Culture and mental health in undergraduate health

which has been published in final form at
http://dx.doi.org/10.1111/inm.12350

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Key words
Cultural competence curriculum, education, mental health,

Abstract
Australia is a country rich in cultural diversity, with Indigenous Australians having specific cultural values and a variety of different spoken languages. In addition, the increasing number of people from migrant and refugee backgrounds, requires that health professionals be able to communicate effectively with people from a wide range of cultural backgrounds. This is particularly relevant when undertaking a mental health assessment, because members of diverse communities often face the dual vulnerability of marginalisation and stigmatisation. This paper reports on the development and evaluation of an innovative virtual teaching and learning resource that prepare health students to be culturally competent in mental health assessment. Four online interprofessional learning journeys were developed; each can be used as part of a teaching package or independently. Evaluation of the usefulness of the learning resources as well as the cultural competence of students was conducted across three participating Australian universities. Quantitative evaluation involved pre- and post-testing using an empathy scale, mental health nursing clinical confidence scale and a cultural competence questionnaire informed by the theory of planned behaviour. Qualitative data from focus group interviews explored participants’ experiences of using the guided learning journey. Participants reported changes from pre-test to post-test in their empathy and attitudes toward culturally and linguistically diverse consumers with significant positive changes in cultural competence, empathy and attitudes. There was strong satisfaction with the learning materials indicating that participants valued this ‘real world’ learning experience.
Results require cautious interpretation given recruitment difficulties in the evaluation phase. However, these learning journeys appear to have potential to be an effective way to challenge attitudes and perceptions as well as increase cultural competence toward culturally and linguistically diverse consumers.

**Introduction**

The increasing cultural diversity of populations in Australia has seen an emerging focus by governments and health professional regulatory bodies on ways to better address cultural issues in the provision of health care (NHMRC, 2005; Royal New Zealand College of General Practitioners, 2007; RPNRC, 2014). In this paper we report on a project involving the development and evaluation of an innovative virtual teaching and learning resource to prepare health science students (nursing, health sciences, disability, paramedics and midwifery) with cultural competence in the context of mental health assessment and support needs of specific cultural populations. The project responds to the high prevalence of mental health problems in the Australian population (ABS 2008) and the need for health professional graduates to be skilled and knowledgeable in the mental health care needs of individuals from culturally diverse populations (Mental Health Nurse Education Taskforce 2010).

**Background**

Australia is a nation of diverse people separated culturally as well as geographically. Indigenous Australians are the country’s first people and comprise thousands of different groups, many of which speak languages other than English. In a country of 24.5 million people, 2.5 % are indigenous. In some areas of Australia, such as the Northern Territory and Northern Queensland, the prevalence is much higher, and
many indigenous people there live a traditional life style and in remote conditions. Australia also has populations of migrants from Yugoslavia, United Kingdom, Greece and Italy in the years following the Second World War, Vietnamese, Cambodian and other Asian groups following in country conflicts, and more recently refugees from Africa and the Middle East. Planned migration over the last 90 years has seen 6 million people come to Australia from 150 countries (Australian Government 2007). Today 25% of Australians are born overseas and Australia is one of the most culturally diverse countries in the world (NHMRC 2005). Over 27 per cent of Australia’s population is from migrant and refugee backgrounds (ABS 2012a).

When one belongs to the mainstream, culture may be a part of one’s identity that is taken-for-granted and unnoticed. But members of minority cultures may be very aware of their beliefs, traditions and language that sometimes set them apart from others and impede communication and understanding. For health professionals who explicitly value acceptance of all people, regardless of age, creed, class or culture, it is vital that difference be accepted and that cultural awareness be highly developed. In this project, we defined culture as: “a set of basic assumptions and values, orientations to life, beliefs, policies, procedures and behavioural conventions that are shared by a group of people, and that influence (but do not determine) each member’s behaviour and his/her interpretations of the ‘meaning’ of other people’s behaviour.” (Spencer-Oatey 2008 p. 3).

In this definition, culture is a dynamic concept in that not all group members share identical sets of attitudes and beliefs but there may be close similarities within each group. Kimayer (2012) has argued that it is vital for mental health professionals to
study culture because it has an influence on one’s vulnerability to, or even resistance from, developing a mental health problem. Those who are isolated, impoverished, or marginalised because of their culture may experience adversity and thus be at risk of disorder. On the other hand, those who enjoy strong family and social support may experience more meaning and happiness in their life. It is a sad reality that within mental health history there is a legacy of inequitable diagnosis and treatment of people from minority cultures (Cross & Singh 2012).

In order for health professionals to become part of a positive change in terms of access and service equity, it is vital that they learn and develop cultural competence, defined as a set of congruent knowledge, behaviours and attitudes amongst health professionals that enable them to work effectively in cross-cultural situations. (Giddens et al., 2012). Increasingly, many health educators are developing innovative ways to enhance cultural competence. A meta-analysis of educational interventions for enhancing cultural competence in nurses and nursing students found varied effectiveness of these interventions, but saw potential for cultural competence training (Hallagher & Polanin, 2015). A recent Cochrane review identified some support for cultural competence education for health professionals, with randomised controlled trials either showing support for the educational interventions or no evidence of effect (Horvat et al., 2014). Reviews such as these demonstrate that while there is some evidence that education by cultural competence training might have an effect on health professionals’ knowledge and attitudes, there is considerable variation in approaches and because of this variation, little understanding of what works (Dykes & White, 2011). While mental health and cultural issues have been taught for many years in undergraduate nursing and health sciences’ courses, they have rarely been
combined and taught in a unified manner. This project was designed to bring together the educational content of mental health assessment and treatment of mental health problems with culturally specific content to prepare health professionals for culturally competent practice.

Specifically, the project aimed to:

a) Design and develop virtual teaching and learning resources to prepare health sciences students with cultural competence in the mental health assessment and treatment of specific cultural populations

b) Evaluate students’ perceptions of the usefulness of the resources to their learning

c) Evaluate the impact of the learning resources on students’ cultural competence.

Methods

Development of the virtual teaching and learning resource

Three well-substantiated teaching principles informed the development of the online learning resources: storytelling, case-study based learning and interpretive pedagogy (Giddens 2007, McAllister et al., 2009). An interpretive pedagogical approach aims to help students develop a deeper understanding of complex concepts and to develop requisite cognitive skills (Ironside 2004, 2006). This approach promotes knowledge acquisition through multiperspective thinking. Storytelling uses the lived experience of consumers and health professionals by which students can learn in a meaningful context. Case studies are a widely-used teaching strategy involving “analysis of a clinical situation or incident” (Giddens, 2007, p. 253). Case studies can have (as in this project) a number of time points and thus unfold over time, providing ongoing
exposure to a concept and facilitating deep understanding (Giddens 2007, p.251).

Thistlethwaite et al. (2012) conducted a systematic review of 104 studies investigating the use of case based learning in health professional education, finding overwhelming support for this method from both students and teachers.

In this project the three teaching principles were brought together in the form of 'guided learning journeys' - complex, authentic, evolving case studies that include strong emphasis on the consumer voice and therefore the storytelling component of cases advocated by Giddens (2007). To avoid fostering a stereotypical view of a particularly person or culture, case studies were designed in such a way as to utilise real narratives from a range of people from different cultural backgrounds. The specific use of video and audio tools allowed their stories to unfold, providing information on the challenges of being from a minority population, identifying strength, resilience and the different cultural values, beliefs, and needs unique to each person. The scaffolding of information and resources within each learning journey allows students to challenge stigma and dispel stereotypes by developing a deep understanding of their own values and beliefs related to culture and different cultural populations, explore a range of mental health issues from the perspective of the individual, identify culturally safe practice in mental health assessment and acknowledge the strengths and limitations of their own practice.

Interpretive pedagogy theory was applied in an interpretive manner so that multiple, socially constructed truths, perspectives and realities were recognised (Ruey 2009). This helps foster an awareness of different perspectives among participants in health care, which is essential to the development of cultural competence and interprofessional care (Hunter & Krants 2010). Morrissey et al. (2011) identified
barriers to inter-professional mental health education, including insufficient materials and organisational barriers. In order to overcome these barriers, the journeys were designed to be self-paced, self-contained virtual learning environments able to be added to existing curricula across a range of disciplines.

A national project reference group of content experts including people with lived experience, with the required specialist and personal knowledge relating to Indigenous Australian and culturally diverse issues and mental health, was established at the start of the project. They worked collaboratively with the project team to identify priority areas, and provide feedback during the development process. Four guided learning journeys were developed using audio, video and images of actors, they are fictitious in nature but informed by real cases. Close collaboration with community stakeholders ensured the resources were culturally appropriate and highly relevant. The Poche Indigenous Health and Wellbeing Centre, SA as well as, state Migrant Resource Centres and state Health and Chinese Welfare Services provided cultural guidance to the production of the following journeys:

This journey followed three people: Justin, Sui and Shannon. A fourth journey focused on a group of refuges and migrants.

Justin O’Dowd is a 20-year old Indigenous man with diabetes and complex mental and physical health problems.


Sui Fang is an 80-year-old woman, originally from Hong Kong, residing in Sydney with her family. This learning journey allows the impact of cognitive
decline (dementia) on an immigrant Chinese family and associated culturally specific issue to be explored.


Shannon Bycroft is a 20-year-old Aboriginal woman from a rural area in Australia who is pregnant with her first child. Exploration of and understanding about racism, culture, puerperal psychosis and mental health assessment is explored in this learning journey.


The Migrant and Refugee Resilience and Wellbeing learning journey explores the mental health and wellbeing of refugees and migrants with people from a number of countries telling their stories of arriving and settling in Australia


In addition, a further educational resource was developed entitled ‘What do health professionals actually do?’ In this resource, 11 health professionals describe their role and what drives their passion in their chosen career. All the learning materials are available online in an open access format (http://www.flinders.edu.au/nursing/mhs/).

**Evaluation of the Guided Learning Journeys**

An initial evaluation was undertaken at Flinders University prior to the full implementation at three universities in large cohorts. Ethics approval for the evaluation of the project was gained from the University’s Social and Behavioural
Research Ethics Committee (approval numbers 6488 and 6844) and reciprocal ethical approval was provided by the Human Research Ethics Committees of the two other Universities.

Initial evaluation took the form of two focus groups with undergraduate students to explore how students navigated the first learning journey Justin O’Dowd. Fourteen health sciences students participated, of which 12 were undergraduate nursing students and two were undergraduate paramedic students. Refinements were made to the learning journey based on student feedback. Feedback referred to the needed changes to be made to improve the layout of the landing page (the welcome page of the learning journey) so that it was easier for students to orient themselves to the various time point modules of learning activities. Changes were also made to how the learning journey was scaffolded. Scaffolding refers to the variety of instructional strategies used to move students progressively through learning activities. Other changes included the need to provide more clarity to some of the instructions about learning activities to enhance students understanding of what was required. All amendments were made prior to implementation at three Universities.

**Recruitment strategies for the evaluation**

The learning journeys were trialed in courses at three Universities. At University A, students were initially recruited through participation in a first year nursing subject, where an assignment was tied to Justin’s learning journey. Due to initial lack of take up emails were then sent to Nursing, Allied Health and Disability students (years one to three) at University A. The lack of original uptake was surprising as all students in the course had to engage with the learning journey as part of their normal program of
study. At University B and University C, students in two topics were sent emails inviting participation. Students were asked to complete the learning journey complete the pre- and post- tests (three questionnaires) and then take part in a focus group or interview exploring their views and experiences, for which they received reimbursement for their time and travel commitments.

Quantitative evaluation consisted of students who undertook a learning journey completing measures of their empathy, clinical confidence and cultural competence prior to and subsequent to undertaking the learning journey. The qualitative component involved the use of a semi-structured interview schedule in focus groups and one to one interviews to establish how useful to their learning the activities were and how it impacted on their perceptions about culture.

**Quantitative evaluation**

Quantitative evaluation involved pre- and post-testing using the Mental Health Nursing Clinical Confidence scale (Bell et al., 1998), the Kiersma-Chen Empathy Scale (Kiersma et al., 2012) and the Cultural Competence Questionnaire (TPB-CCQ). The Mental Health Nursing Clinical Confidence scale (Bell et al., 1998) is a 20 item self-report scale with robust psychometric properties. The scale was designed to assess student confidence pre and post clinical placement. While students in this project were exposed to a specific clinical case rather than an actual clinical placement, the project team assessed the tool as useful in this study as the questions were generic in nature and were directly relevant to students’ exposure to new knowledge and learning about mental health assessment and treatment through the learning journey, and as such this would be a useful measure to assess confidence about preparedness to go into clinical practice. The Kiersma-Chen Empathy Scale is
a 15-item instrument comprised of cognitive and affective empathy domain with demonstrated reliability and validity of a new scale for evaluating student empathy (Kiersma et al., 2012). The Cultural Competence Questionnaire (TPB-CCQ) is a 30-item instrument with prior evidence of psychometric integrity (Levett-Jones et al., under review). This questionnaire was developed using the Theory of Planned behavior (TPB), which asserts that behavioural intentions are the main determinants of actions, and intentions themselves are influenced by attitudes, subjective norms and perceived control (Ajzen 1991).

Participants
Seventy-two students completed the measures at Time 1 and/or Time 2. Of these 72 students, 29 were excluded from analyses either because they completed the measures at only one time point ($n = 9$), or they did not allow sufficient time (> 1 hour) to complete the learning journey ($n = 20$) The project team agreed that if students completed both the pre and post test within one hour, it was very unlikely that they had engaged with the educational materials in any meaningful way. Thus, those students’ data were excluded from the analyses.

The final sample, therefore, consisted of 43 participants. The median time between completing Time 1 measures and commencing Time 2 measures for these students was 49.19 hours ($IQR = 131.07$; Range = 1 hour 4 minutes-47 days).

Thirty-two (74.42%) participants were University A students, with lesser participation for University C ($n = 8$) and University B ($n = 1$). Two participants did not specify at which university they were enrolled. The largest number of participants completed the Justin O’Dowd learning journey ($n = 32$, all of these participants from University A),
with six participants completing the Sui Fang journey and six the Shannon Bycroft journey. All participants were nursing students.

Qualitative evaluation

Participants

A total of 21 students participated in focus groups and interviews. A semi-structured interview guide was developed with the aim of exploring students’ perceptions and experiences of the guided learning journey (Appendix One). The majority of participants were female \( n = 16 \) and studying nursing \( n = 11 \), and year levels ranged from first year to Post Graduate. Originally recruitment was sought from only undergraduates but due to lack of participant uptake, this was extended to postgraduate students. There was multidisciplinary representation from nursing \( n = 11 \), paramedics \( n = 2 \), nutrition \( n = 1 \), health science/nursing \( n = 1 \), physiotherapy \( n = 1 \), teaching \( n = 1 \), special education \( n = 1 \), clinical science/medicine \( n = 1 \) and disability studies \( n = 1 \), with one participant not specifying their discipline. All nurse participants had completed the quantitative data aspects of the evaluation but none of the other health students had.

Analysis

The focus groups and interviews were audiotaped and transcribed in note form. The transcripts and online discussion group data were analysed using a Framework Analysis approach. This approach is particularly suited to applied research that has specific questions, a limited timeframe, a pre-designed sample, and a priori issues that are to be explored (Strivastava & Thomson 2009).
Results and Findings

Quantitative results

Internal consistency reliabilities (using Cronbach’s alpha) were calculated for the measures. In the present study alphas were > .70 (Field, 2009) for the following scales: empathy .79 (pre-test), .72 (post-test); confidence .78 (pre-test), .89 (post-test); and attitudes .83 (pre-test), .81 (post-test). The alphas for intention were lower (.66 at both pre-test and post-test). For perceived behavioural control and subjective norms, the alphas were extremely low, and the decision was made to exclude these measures from further analysis.

Data were screened for univariate ($z > 2.50$) and multivariate outliers (via Mahalanobis distance; $p < .001$). This resulted in the removal of two univariate outliers; no multivariate outliers were identified.

Table 1 presents the means, standard deviations, and ranges for the measures for Time 1 to Time 2. Participants reported high levels of empathy at both pre-test and post-test. Scores on confidence and theory of planned behaviour variables were more moderate, but also on the higher end of possible maximum scores.

Changes from Time 1 to Time 2

Four paired samples $t$-tests were conducted to investigate whether participants’ scores significantly changed from pre-test to post-test on es: (1) empathy; (2) clinical confidence; and the theory of planned behaviour variables (3) attitudes; and (4) intention. In light of the number of statistical tests conducted, a Bonferroni adjustment was applied ($p = .01$). Effect sizes ($r$) were calculated to investigate the magnitude of observed effects, with $r = .10$ indicating a small effect; $r = .30$ a medium effect; and $r = 0.50$ a large effect size (Field, 2005).
Empathy. Participants reported a significant increase in their cognitive and affective empathy for consumers from Time 1 \((M = 85.77, SE = 1.23)\) to Time 2 \((M = 91.05, SE = 1.06)\), \(t(41) = -5.04, p < .001, r = .62\) (large effect).

Confidence. Participants reported a significant increase in their confidence from Time 1 \((M = 20.79, SE = .62)\) to Time 2 \((M = 24.71, SE = .63)\), \(t(41) = -5.81, p < .001, r = .67\) (large effect).

Cultural competence. Participants reported a significant increase in their attitudes from Time 1 \((M = 40.45, SE = 1.41)\) to Time 2 \((M = 44.14, SE = 1.38)\), \(t(42) = -4.45, p < .001, r = .56\) (large effect). They also reported a significant increase on intentions from Time 1 \((M = 17.49, SE = .45)\) to Time 2 \((M = 18.65, SE = .37)\), \(t(42) = -3.50, p = .001, r = .47\) (medium to large effect).

Since the majority of participants were from University A, and all of these students completed the Justin O’Dowd journey, \(t\)-tests were also run with only these participants. The results for all measures were similar using this subsample, and so the analysis with all 43 participants is reported in text.

Qualitative findings

The following themes were derived from the data, which focused on the participants’ perspectives on the experiences of undertaking the learning journey, their perceived learning and increase in knowledge base.

The usefulness of the guided learning journey

The students were overwhelmingly positive about the guided learning journeys stressing that the journeys reflected real world practices.
‘It was just really well done…the whole thing…and how it took you from that very beginning stage and just walked you through each step throughout the journey’. Focus Group 2

Useful aspects appeared to be the ability to follow a realistic journey, and delve deeply into the cultural situation and its impact on mental health through the range of resources available. The videos were identified as being particularly useful.

‘The videos provided insight into how you might support an Indigenous person from a remote community in a hospital in the city’ Interview 2

Presenting the case study using multimedia was viewed as superior to a written case, allowing students to engage with Justin as a real patient not ‘just a case’ and having to use critical thinking skills (Interview 1). Comments were also made in relation to the different ways the journeys were embedded in courses. For example, students who had an assignment to complete based on the journey described the material as extremely useful and commented that was a specific motivation to go through the journey in great depth.

When discussing how the learning journey could be made more useful, students suggested including videos that focused on undertaking a mental state assessment in a specific cultural setting. Further, they expressed wanting information about how to work with interpreters. The mix of multimedia appeared to suit many learning styles. Students enjoyed the ‘storytelling’ of the journeys and indicated that the rich narrative caught and held their attention. When asked about aspects that they found least useful, only the large amount of material in the journey was identified, suggesting that some students may not access all components of the learning resources. Students also suggested that videos need to be transcribed so they could be accessible when Internet access was patchy.
**Impact of the guided learning journey**

According to the data, this learning experience was the first opportunity many had in learning about a range of cultures and was described as ‘quite enlightening’ (Focus Group 1). Justin’s journey was viewed as having a positive impact on students’ attitudes towards mental health and culture by providing students with knowledge on Indigenous culture and mental health that was either new to them, or reinforced existing knowledge gained in other courses, as indicated in this comment:

> ‘It has raised awareness about how complex and interwoven the issues are, I mean weaving mental health issues and the cultural factors together’

Focus Group 3.

Similarly, students reported that the journey either changed their attitudes to culture and mental health or reinforced pre-existing attitudes. Students identified that the journey would influence their future practice when dealing with issues of culture and mental health by them having a raised awareness of potential cultural issues to consider in providing care. The journey was also described as improving the students’ confidence in caring for people with mental illness. However, they generally felt that while the journey gave them some confidence about being culturally competent as health professionals, they would need more learning and exposure before they felt confident working autonomously with specific cultural groups.

**Discussion**

This study aimed to design, develop and evaluate virtual online learning resources to prepare health science students with cultural competence in the mental health assessment and treatment of specific cultural populations. Evaluation demonstrated a
positive impact on students’ empathy, attitudes towards culture as well as clinical confidence. Participants reported changes from pre-test to post-test in their empathy and attitudes toward culturally and linguistically diverse consumers; intentions to advocate and practice in a culturally safe way with such consumers; and confidence to communicate effectively, perform mental state assessments, and other key tasks in the clinical setting. These changes were statistically significant and demonstrated medium to large effect sizes. This suggests that the learning journeys may be an effective way to facilitate change and challenge attitudes and perceptions toward culturally and linguistically diverse consumers.

The importance of nurse empathy and positive attitudes and intentions toward consumers has been demonstrated in previous research. Empathy is a core component of the nurse-consumer relationship (Kunyk & Olson 2001), and leads to clinical benefits (Forchuk et al., 1998). Similarly, attitudes toward consumers and attributions for behaviour affect nurses’ empathy and intended helping responses (Forsyth 2007). In the present study, empathy scores were relatively high at pre-test, which is positive given the importance of empathy in nursing care. Other studies have demonstrated that paramedic students have lower empathy scores than those reported by health care students in the literature (Williams et al., 2016). Ward, (2012) reported declines in nursing students’ empathy over time, with the suggestion that exposure to consumer narratives and simulation could be amongst strategies to enhance empathy skills.

Findings of strong satisfaction with the learning materials indicates that participants valued this ‘real world’ learning experience. Students were positive about their experiences of using the online guided learning journey, and were positive about the impact of the journey on themselves and their practice. These findings support existing literature that identifies that students thrive on real and complex cases and
that case studies assist the development of problem solving, teamwork and decision making skills (Tunny, Papinczak & Young 2010). Our findings also support the use of media such as videos and podcasts to ‘bring to life’ case studies and maintain student learning through the learning journeys. Finally, the findings demonstrate that students’ cultural competence and confidence increased as a result of their engagement with these educational materials supporting the interpretive pedagogical stance on which they were based.

Limitations

It was our aim to trial these materials with a cross section of health disciplines but for a number of reason this was not possible. Two universities anticipated recruitment from health sciences and paramedics but this did not occur. Thus the findings need to be interpreted with caution but can offer some insights. In the quantitative evaluation, the pre and post testing time frame was short and future evaluations ought measure changes in student attitudes and perceptions over a longer period (e.g. start and end of semester), or students should be advised of (or the web survey enforce) a minimum time between completing the learning journey and post-test measures. Reliability of measures was also an issue, with two measures not demonstrating adequate reliability, and this meant that they were not used in subsequent analysis. Another potential limitation is the small group size that may have been more motivated to share positive experiences than those who took part. Participants in the quantitative data phase were all nursing students and this is a limitation in disallowing any inferences about significance of findings across interprofessional groups. The nature and dynamics of interprofessional learning and preparation for professional practice continue to be important areas worthy of further investigation.
**Relevance for clinical practice**

A number of implications become evident from this educational research. Students who engage with vivid case studies that foreground mental health and cultural difference develop an increased awareness of the need for sensitivity in their communications and their empathy for consumers’ vulnerability increases. These values are vital for mental health nursing practice, which depends on clinicians who can forge trust, engagement and openness, thus promoting consumers’ willingness to engage in therapeutic interventions. Further, that real world ‘cases’ are a potent learning experience for students entering the health workforce which promote the development of cultural competence.

**Conclusion**

It is vital that health professionals are culturally competent when caring for people from diverse cultural backgrounds with a mental health problem. This study aimed to evaluate the usefulness of educational materials for health professionals focussing on culture and mental health issues as well as the impact on students’ learning. Positive changes were demonstrated in students’ cultural competence, empathy and attitudes although in a small sample size. The findings arising from this study present some evidence that supports the use of online educational materials to increase cultural competence in undergraduate health students. The use of authentic cases with various time points over the ‘learning journey’ has been shown to be useful preparing health students for the exigencies of caring for people with mental health problems from diverse cultural backgrounds. Further investigations into the value of educational materials preparing students with cultural competence in the context of mental health care can assist in establishing an evidence base for undergraduate health curricula.

**References**

Accessed November 9th 2016


**Tables**

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<thead>
<tr>
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<td></td>
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<td>Range</td>
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<td>Intention</td>
<td>43</td>
<td>17.49 (2.92)</td>
<td>12-21</td>
</tr>
</tbody>
</table>

*Note: N does not always total 43 due to the removal of univariate outliers. While a participant may have had a univariate outlier on a measure at one time point (e.g. Time 1 but not Time 2), to simplify reporting, their data for both time points for that variable have been removed.*

**Appendices**

**Appendix 1: Interview and focus group questions:**

What aspects of the guided learning journey did you find most useful and why?

What aspects of the guided learning journey were least useful?

How could the guided learning journey be made more relevant to your learning?
Do you think students will work through all of the guided learning journey in depth?

Did the guided learning journey change your attitudes to people from different cultures?

Did the guided learning journey change your attitudes to mental health?

Should special consideration be given to patients according to their individual cultural preferences? Has working through the guided learning journey influenced your answer?

After using the guided learning journey are you more confident with culturally safe care strategies used to assist mental health recovery?

Has the guided learning journey influenced your personal attitudes and values regarding cultural interpretations of mental illness?

Has using the guided learning journey improved your confidence in caring for people with mental illness?