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Development of a Multicultural Mental Health Awareness Scale

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Abstract

The present study describes the development of an instrument to assess the multicultural competencies of mental health professionals in Australia. The scale was developed to assess the effectiveness of a multicultural mental health training program. Mental health professionals from Queensland, Australia (N = 268) participated in the study by completing a questionnaire battery. Items on the new scale were generated to parallel the Queensland Transcultural Mental Health Centre (QTMHC) training program's objectives. The results describe a 35-item Multicultural Mental Health Awareness Scale. Factor analysis of the scale revealed three factors of multicultural counselling competencies: Awareness, Knowledge, and Skills. These factors were in line with Sue et al.'s (1982) multicultural counselling competencies. The scale has satisfactory internal consistency, test-retest reliability, concurrent validity, and discriminant validity and can be used to evaluate the effectiveness of the multicultural competency training programs in mental health.

Key words: Multicultural competency, scales and mental health

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Australia is one of the most multicultural societies in the world with one in three people identifying as being born overseas (Commonwealth of Australia, 2004). Significant changes within the migrant population have occurred since 1901 from a mainly Anglo-Celtic base to a universal multicultural society (Weston, Qu, & Soriano, 2003). Over 200 languages are spoken (Commonwealth of Australia, 2004), making Australia one of the most diverse migrant populations by international standards (Rao, Warburton, & Bartlett, 2006). There is also a considerable diversity of size and spread of various ethnic communities in Australia, which has a relatively small overall population spread across a large continent. Keeping in view the cultural diversity in Australia, the Ministerial Council on Immigration and Multicultural Affairs met in May 1996 to coin the term "culturally and linguistically diverse" (CALD). Cultural and linguistic diversity refers to the wide range of cultural groups that make up the Australian population and Australian communities (National Medical Health and Medical Research Council, 2005). The term is used to represent individuals, who were born overseas, or have parents who were born overseas (Australian Bureau of Statistics, 1999). Further, these individuals are identified on the basis of specific culture, religion or language. English is not their first language and they may have varying degrees of English language proficiency. Refugees and migrants, who settle in Australia, fall in this category (Griffiths, 2005). The Indigenous population, who may share some features with migrants and refugees, are considered distinct being the first people in Australia. The term CALD is used in the present paper to represent migrants, refugees and / or their children.

Mental Health Issues of the THE CALD Population

CALD individuals, who are new arrivals in Australia, encounter a range of pre and post migration difficulties (Heptinstall, Sethna, & Taylor, 2004). Refugees, who enter Australia to flee from the dangers and persecution in their own country of origin, may bring with them trauma and loss (Department of Immigration and Multicultural Affairs, 2006). In general, arrival into a new country may lead to adaptation and acculturative stressors (Gorman, Brough, & Ramirez, 2003). These factors, coupled with a lack of environmental mastery, social support, English language proficiency and socio economic status have an impact on the mental health of the CALD population (Rao et al., 2006). These psychosocial stressors, introduced by migration circumstances and geographical locations, tend to yield a higher rate of mental disorders (Steel, Silove, Chey, Bauman, & Phan, 2005) which are also evident in epidemiological studies amongst refugees and war-effected populations (Steel et al., 2005) and among individuals from a non-English speaking background (National Survey of Mental Health and Wellbeing as cited in Rao et al., 2006). Such mental disorders associated with migration experiences may include anxiety, depression, post traumatic stress disorder, substance abuse and even an acute onset of psychoses (Bhugra, 2004). Furthermore, role and intergenerational conflicts are commonly reported by those who migrate to a new country (Ng, 2006).

Mental health issues of CALD population need special professional attention at clinical and service planning levels (Ng, 2006). Regardless of Australia being officially acknowledged as a multicultural society, its healthcare system has predominantly been mono-cultural (Anglo-Celtic) and therefore CALD clients are often deprived in terms of access and quality of service (Gorman et al., 2003). Individuals belonging to various ethnic groups can have a cultural and traditional explanation for their illnesses, experiences, recovery and healing processes (Bhui &

Bhugra, 2002). For example, in some cultures mental illness may be considered a sin or a curse resolved by a spiritual healer or a cultural ritual (Bhui & Bhugra, 2002). These explanations, referred to as explanatory models, can be very different to the western ideology (Kendler, 2008). Very often these individuals' beliefs and explanatory models regarding mental illnesses and accessing mental health services lead to their underutilisation of such facilities (Rao, et al., 2006; Thompson, Hartel, Manderson, Woelz-Stirling, & Kelaher, 2002). In addition, CALD individuals have a lack of awareness of such services in Australia due to an absence of mental health services in their countries of origin (Rao et al., 2006). Language barriers also hinder CALD individuals in expressing their emotional problems (Thompson et al., 2002; Wynaden, Chapman, Orb, McGowan, Zeeman, & Yeak, 2005). Furthermore, the available mental health services and professionals who provide these services, also contribute to the underutilisation of mental health services by CALD individuals. Services that are 'inequitable' and 'substandard' resulting from a lack of understanding of cultural issues and a lack of ethno-specific workers tend to discourage CALD clients from using the services (Barker & Hartel, 2004; Gorman et al., 2003).

Multicultural Counselling Competencies

Concerns with the available mental health services for the CALD population highlight the need for culturally competent counselling services (Kim & Lyons, 2003). The concept of multicultural counselling competencies (MCC) was first introduced by Sue et al. (1982). The first official description of multicultural counselling competence, developed by the Education and Training Committee of the American Psychologocal Association's Division of Counseling Psychology (Division 17), was defined as the combination of a counsellor's attitudes/beliefs, knowledge, and skills in multicultural counselling (Sue et al., 1982, 1992; D'Andrea, Daniels, &

Heck, 1991). Thus, multicultural counselling happens when culturally-specific attitudes or beliefs (awareness), knowledge, and skills are integrated into clinical practice (Arredondo et al., 1996; Sue, Arredondo, & McDavis, 1992; Sue et al., 1982). The attitudes/beliefs or *Awareness* component focuses on the responsibility of mental health professionals to gain awareness of their own ethnic customs, biases, values, and cultural attitudes and to consider how these aspects may influence psychological processes and counsellors' interactions with clients from different backgrounds (Sue et al., 1992). Awareness also includes the development of more accurate and appropriate attitudes, judgements, and assumptions about culture in the counselling setting (McRae & Johnson, 1991).

The *Knowledge* dimension is characterised by specific knowledge of cultural groups, the role cultural ethnicity plays in personality formation, manifestation of psychological disorders and help-seeking behaviours. It also includes understanding of the barriers preventing minorities from using mental health services and the appropriateness or inappropriateness of counsellors' approaches (Sue et al., 1982). The *Skills* dimension refers to the professionals' abilities to translate attitudes/beliefs and knowledge into culturally correct intervention strategies incorporating an appreciation of the client's life experience and values/beliefs. It involves effective communication with CALD clients, actively seeking training, and the ability to obtain assistance or supervision to improve multicultural counsellors' proficiencies (Sue et al., 1992). The multicultural movement has increased the significance of multicultural competencies in practice and research and, in general, training is recognised as a requirement to achieve these competencies (D'Andrea & Daniels, 1991; Sue et al., 1992).

Transcultural Services in Australia

Given the diversity of ethnic groups residing in Australia, ethno-specific services are not feasible. As such, a 'mainstream' model of mental health service has been adopted (Kirmayer & Minas, 2000). This approach involves the Multicultural Mental Health Australia organisation linking a wide range of state and territory mental health specialists and services, advocacy groups and tertiary institutions to promote the mental health and well being of Australia's diverse communities. In addition, state-wide specialist transcultural mental health centres provide education, support and consultancy to mainstream public mental health services to develop and deliver high quality mental health care for all members of the community, particularly those from CALD backgrounds. Queensland Transcultural Mental Health (QTMHC) is the state-level specialist service that operates in Queensland. Along with its consultancy and supportive roles, it conducts training programs for mainstream clinicians to enhance their cross-cultural awareness, knowledge and skills, thus promoting effective mental health services for the CALD consumers.

While there is broad agreement on the need for cultural competency, defining what constitutes cultural competency is contentious. Kleinman and Benson (2006) note that while cultural competency has become a fashionable term for clinicians and researchers no one has defined the term precisely enough to operationalise it for clinical training or best practice. Kleinman and Benson (2006) argue that cultural competency can become a series of "dos and don'ts" that define how to treat a consumer of a given ethnic background and they warn of the dangers of this approach. In support of this argument, Turner (2003) from the QTMHC has also argued that cultural competency is a process and not a list of specific activities. QTMHC's professional development program provides clinicians with some knowledge and skills in transcultural assessment and treatment and increases their awareness of potential cultural

contexts and variables so that they can 'think on their feet' and maximise the potential of achieving positive clinical outcomes (Turner, 2006).

This 'process' approach to cultural competence, is shared by others in the mental health field. For example, Bussema and Nemec (2006) note that cultural competency training is as much about exploring and changing attitudes, and increasing awareness of the personal biases that we all inevitably hold, as it is about transmitting knowledge about culture, diversity, and identity. In contrast to 'culture specific competency', Fitzgerald (2000) defines 'culture general competency' as "the ability to function in the ambiguous, dynamic, open-ended interactions common to therapy situations for which no adequate cultural blueprint exists" (Fitzgerald, 2000, p. 187). Turner (2003) advocates for 'culture general competency' in training and education stating that "in multicultural Australia our health professionals need to be equipped with knowledge and skills in working with individuals and families who are moving from one culture to another" and "the ability to tolerate ambiguity and apply flexible approaches to suit the unique individual needs of the client should be focused on" (p. 16).

In Australia, the QTMHC offers a nine module professional development program on managing cultural diversity in mental health. The program is designed to equip participants with the knowledge, skills and awareness required for 'culture general competency' in multicultural mental health. Eight of the modules form a postgraduate course offered by the department of psychiatry of a Queensland university. Although the program has been in operation for over five years there have been no formal evaluations of whether the program has increased the awareness, knowledge and skills of participants in regard to multicultural mental health. One of the reasons for the absence of a formal evaluation is the lack of an appropriate valid scale to measure multicultural mental health competencies.

It is important to utilise multicultural scales to systematically assess the efficiency of training programs in the development of multicultural counselling competencies in professionals. A relatively small amount of attention has been directed toward the development of psychometrically sound and conceptually anchored instrumentation for evaluating multicultural training (Ponterotto, Riegar, Barret, & Sparks, 1994). There are, however, a number of scales that have been designed to evaluate counsellors' multicultural counselling competencies. These include the Cross-Cultural Counselling Inventory-Revised (CCCI-R; LaFromboise, Coleman, & Hernandez, 1991), the Multicultural Counseling Awareness Scale (MCAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2000), the Multicultural Awareness-Knowledge-and-Skills Survey (MAKSS; D'Andrea et al., 1991), the Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994) and Multicultural School Psychology Competency Scale (MSPCS; Rogers & Ponterotto, 1997). Although all these instruments claimed to be based on the multicultural counselling competency constructs defined in previous research (Constantine, Gloria, Ladany, 2002; Constantine & Ladany, 2000; Ponterotto et al., 2000; Sue et al., 1982, 1992) there are discrepancies between the model and the scales. The scales vary to the extent they reflect the Sue et al. (1982) model, with the CCCI-R, MCAS and MSPCS coinciding with the model to some degree; however, MAKSS and MCI were derived from the literature on counsellor training, competency and ethics (D'Andrea et al., 1991; Sodowsky et al., 1994).

Critical evaluation of the scales indicated that despite using various item development procedures to capture the multicultural counselling competence in the Division 17 position paper, the scales produced different numbers of factors and inconsistencies within the same-named factors (Constantine et al., 2002; Kitaoka, 2005). Factors ranged from one (LaFromboise et al., 1991) to five (Sadowsky et al., 1994). The factor structure of some of the scales, such as

the MCI (Kitaoka, 2005) is questionable. Even though similar competencies were adopted to construct items, the instruments differed on the basis of item sources and interpretations (Pope-Davis & Dings, 1995). Furthermore, the literature does not provide clear descriptions or definitions of what the subscales of all of the instruments purported to measure (Kocarek, Talbot, Batka, & Anderson, 2001). There appears to be a discrepancy between factor structures and the dimensions of the multicultural competency model (Kitaoka, 2005).

It is important to note that the reasons to develop the multicultural counselling scales differed. They were developed for very different purposes, such as evaluating counsellors general multicultural competencies, assessing the efficacy of specific academic courses and helping the directors of academic programs to evaluate the elements of multicultural counselling competencies in the courses developed by them (Kitaoka, 2005). Consequently, it has been hypothesised that self-report multicultural instruments may actually be measuring a type of "multicultural counsellor's self efficacy" as instruments are inclined to draw upon respondents' beliefs about providing services to multicultural populations at the given time (Constantine & Ladany, 2000). Further, it is unclear whether the person taking the measure has to imagine him/her self as working with a client from a specific culture or from a range of diverse cultures (Kitaoka, 2005). Additionally, although the scales are reported to be reliable, there is no compelling evidence for their validity and utility (Green et al., 2005).

Due to the above limitations, these instruments may not reflect the philosophies of many academic training programs in applied psychology, thereby making it difficult to accurately assess multicultural competencies (Pope-Davis & Dings, 1995; Sue, Ivey, & Pedersen, 1996). Evaluation of the change as a result of training was not the main purpose to develop these scales (Kitaoka, 2005). The discrepancies in the literature relating to the empirical validation of

multicultural instruments suggest that there is limited research assessing the effectiveness of multicultural training (D'Andrea et al., 1991). The lack of uniformity of these instruments raises concerns regarding validity of the instruments (Coleman, 1998; Pope-Davis & Dings, 1995) and presents sufficient evidence to believe that the scales may not effectively evaluate the QTMHC training and its objectives. This study, then, aims to add to the multicultural literature by developing a scale to evaluate the effectiveness of the QTMHC multicultural training program.

Method

Participants

The participants included a total of 268 mental health professionals. They ranged in age from 18 to 65 years, with a mean age of 39 years (*SD* = 12.43 years; 16 cases had missing data). Table 1 presents information about the participants' gender, marital status, occupation, education, level of multicultural training and ethnicity. As seen by the Table, over two thirds of the participants were women. Nearly half of the participants were married. Most of the participants had a university degree, and were trainee psychologists, clinical psychologists or members of allied health. Two-thirds of the participants identified themselves as Anglo Saxons, while the remaining one-third belonged to other ethnic groups. Half of the participants reported they had not received any multicultural training. Training attended by the others ranged from less than 10 hours to 40 hours.

Measures

Demographic Variables. The demographic scale measured variables including participants' gender, age, marital status, highest education attained, occupation, previous multicultural training, and ethnic background.

Multicultural Awareness-Knowledge-Skills Scale (MAKSS). The MAKSS was designed to measure the results of a multicultural counselling training program on students' multicultural

counselling development (D'Andrea et al., 1991). This paper and pencil measure consists of 60 items. The responses consist of two types of Likert scales with anchors ranging from 1 (*very limited*) to 4 (*very good*) and 1 (*strongly disagree*) to 4 (*strongly agree*), respectively. The MAKSS consists of a three-factor model, where factors pertain to: (1) Awareness (2) Knowledge, and (3) Skills. D' Andrea et al. (1991) presented satisfactory internal consistency with reliability coefficient alphas at .75 for the awareness subscale, .90 for the knowledge subscale and .96 for the skills subscale. Previous studies have reported satisfactory criterion and construct validity (D'Andrea et al., 1991; Ponterotto et al., 1994).

Procedure

Item Generation

An item pool comprising of 51 items, based on the content and objectives of the QTMHC training program, was generated. The instructions referred clearly to CALD clients. The items were sent to 20 experts (psychologists, counsellors and social workers who have extensive experience working with CALD clients) for comments, feedback and short listing. Twelve of these experts responded with suggestions and feedback which were incorporated to improve the clarity of the items. The short listed 44 items were arranged in a questionnaire with the instructions: *Using the following scale, please rate each item truthfully as it applies to you by circling a number using the appropriate scale. Throughout the questionnaire, the abbreviation 'CALD' will be utilised to pertain to individuals who are 'culturally and linguistically diverse'*. The final items were then cross-examined by the staff members of QTMHC who were involved in the training program.

Ethical clearance was obtained from the University's Ethics Committee. The study package consisted of an information letter; an informed consent form; a demographic

information sheet; a copy of the MAKSS and the current scale under development; and a debriefing letter. The debriefing letter attached at the end of the study package served as a thank you note and provided information about how the participants' involvement and assistance was useful for the study. The letter also provided information regarding services participants may approach or contact in the event that their participation in the study had caused them distress. The participants were free to withdraw from the study at any time.

Postgraduate students in psychology enrolled in three universities in Brisbane were approached during their class time (with prior approval from their lecturers) and invited to participate in the project. Participants were provided with either a website address for the online study package or a hard copy of the package. Participants were given the opportunity to complete the questionnaire in their free time and a collection box was placed on campuses for the return of the hard copies. A mailing list of previous participants in the QTMHC Training Program was provided by QTMHC. Half of the individuals on the list were mailed out hard copies of the study package. The other half of the list were then invited to participate in the study through email and provided the website address of the study package. Current participants of the QTMHC Training Program were approached during one of their lectures. They too were informed about the study and invited to participate. Hard copies of the study package were distributed together with reply paid envelopes. In order to increase the sample size, other psychologists whose details were gathered from directories were recruited through email similar to the mailing list of previous QTMHC Training Program participants and provided with the website address of the online study package. Overall, 221 participants completed the entire battery. In order to evaluate the test-retest reliability, participants were invited to complete the scale after a two-week interval. Out of those who volunteered to complete the scale a second time (30%), thirty-seven (14%)

returned the completed questionnaire. To investigate if the scale identified changes in multicultural counselling competencies as a result of QTMHC's training, mental health professionals who attended the training modules were invited to complete the scale before and after the training. The pre and post data were collected for 10 participants.

Results

Data Screening

Prior to analysis, data was examined for accuracy of data entry and missing values. Missing data were replaced with the mean response for the specific variable (Tabachnick & Fidell, 2006). Distributions of the MAKSS and the scale under construction, the Multicultural Mental Health Awareness Scale (MMHAS) were examined for skewness. Results indicated reasonable normality for both scales. An outlier was identified, however this did not exhibit extreme points nor influenced the mean and therefore this case was retained in the data file (Green & Salkind, 2005).

Factor Analysis

The responses of 221 participants to the 44 items were subjected to Principal Components Analysis. Varimax rotation was used to examine the factor structure of the scale (Tabachnick & Fidell, 2006). Eigenvalues and the scree test were used as a criterion to determine the number of factors (Cattell, 1966). Eigenvalues indicated five factors with values greater than one. On the other hand, the scree test (Catell, 1966) indicated one main factor with two smaller factors just above the elbow. A range of options were utilised to determine the final factor structure. Factor solutions of one, three and five factors were explored. Initially, both oblimin and varimax solutions were employed. However a decision was taken to use oblimin rotation only as the factors were correlated. The three factor solution appeared as the most meaningful

and parsimonious solution. The three factor solution reflected the three multicultural counselling competency domains of Sue et al. (1982) with fairly high loadings on each factor. Nine problematic items, that cross-loaded and/or had low communality (less than .30) and low factor loadings (less than .40) were excluded.

Factor Analysis Results for the Final Scale

The factor analysis resulted in a 35–item scale with three factors. The Kaiser-Meyer-Olkin Measure of Sampling Adequacy was .953, indicating an excellent level of intercorrelation among the items (Kaiser, 1974). Similarly, Bartlett's test of sphericity was significant (χ^2 (595) = 8674.462, p <.001). The three factors accounted for 70.29% of the variance. Communalities in the three factor solution ranged from .43 to .81. Each of the three factors was defined in terms of attributes indicating multicultural counselling competency. The scale was labelled as *Multicultural Mental Health Awareness Scale (MMHAS).* See Table 2 for the items and the factor loadings.

Factor 1, *Multicultural Counselling Awareness*, consisted of 15 items and accounted for 59.13% of the variance. This factor focuses on the professionals' awareness of the impact culture has on therapy and work with CALD individuals. Items reflect the effects of both professionals' and consumers' culture on counselling.

Factor 2, *Multicultural Counselling Knowledge*, consisted of nine items and explained an additional 6.89% of the overall variance. These items involved professionals' knowledge and understanding of Australia's policies and services for various CALD individuals.

Factor 3, *Multicultural Counselling Skills*, included 11 items that accounted for an additional 4.27% of the variance. These items focused on the professionals' abilities to develop a culturally

sensitive treatment plan. Furthermore, the items include the degree to which professionals can clearly communicate and build efficient therapeutic relationships with CALD individuals.

The results produced from the full scale generated a minimum score of 35 and a maximum score of 140. The mean score for the sample was 101.81 (*SD* = 25.68, *n* = 221). Scores may also be produced for the individual subscales by adding scores of items that load on those factors. The *Multicultural Counselling Awareness* subscale generated a minimum score of 15 and a maximum score of 60. The mean score for the sample was 49.76 (*SD* = 12.01, *n* = 221). The *Multicultural Counselling Knowledge* subscale produced a minimum score of nine and a maximum score of 36. The mean score for the sample was 21.83 (*SD* = 7.62, *n* = 221). The *Multicultural Counselling Skills* subscale generated a minimum score of 11 and a maximum score of 44. The mean score for the sample was 30.21 (*SD* = 8.10, *n* = 221). The scores for the total as well as the three subscales were normally distributed.

Reliability

Internal Consistency. The results indicate a satisfactory internal consistency for the instrument, both overall and within subscales (*N* = 268*).* The Cronbach's Alpha for the total scale was .91. The internal consistency of the *Multicultural Counselling Awareness* subscale was .89, .92 for the *Multicultural Counselling Knowledge* subscale, and .90 for the Skills subscale.

Test-Retest Reliability. Test-Retest reliability was established with Pearson-R correlation coefficients for thirty seven participants' scores on the MMHAS taken two weeks apart. The correlation coefficient for the overall scale (*r* =.82) and for the *Multicultural Counselling Awareness* (*r* = .79), *Multicultural Counselling Knowledge* (*r* = .88) *and the Multicultural Counselling Skills* (*r* = .84) *subscales* , $p < .01$ indicated a sound reliability. This result supported the scale's stability over time (Tabachnick & Fidell, 2006).

Concurrent Validity. Correlations between the MAKSS and MMHAS were calculated based on the scores of 221 participants and produced low to moderate results (Table 3). Results indicate some similarities between what is being assessed in constructs of both scales. As can be seen by Table 3, an examination of the correlations between the scales and their subscales indicate a moderate correlation. It implies that there is some overlap between the two measures as indicated by items which reflect multicultural counselling, knowledge, awareness and skills. However, the scales are not identical and have their own unique features. While MAKSS is general, MMHAS refers to specific aspects, such as the CALD population in Australia and Australia's multicultural policies and practices. This suggests that both scales can be recognised as two different multicultural instruments with distinct features.

Discriminant Validity. The demographic data indicated that 140 participants had never participated in any multicultural training, while 113 attended some form of training to work with CALD clients. However, the hours and the content of training varied. Data were collapsed into two groups (those without any training versus those with varying degrees of training). Results from an independent t-test were calculated based on the overall scores of the 268 participants who completed the scale to determine whether the MMHAS was able to discriminate between those who have had previous multicultural training and those who have not. Participants with previous multicultural training (M = 104.81, SD = 23.97) had significantly higher scores on the MMHAS than professionals without previous multicultural training (M = 96.61, SD = 26.62), $t(251) = -2.54$, $p < .01$. The results supported the discriminant validity of the scale and reinforced the importance of training. Further, it reinforced the probability of improving mental health professionals' multicultural competency as a result of multicultural training.

As a next step, it was decided to further examine whether MMHAS was able to identify changes in the multicultural counselling competency as an impact of the training program developed and conducted by QTMHC. T-tests were used to compare the responses of 10 participants who attended the QTMHC training program. These participants attended two to eight modules. Each module consisted of a full day of experiential and didactic training. Significant differences between the pre (M = 102; SD = 19.96) and post (M = 130.88; SD = 17.35) MMHAS scores indicated that training improved multicultural competencies, t (9) = 3.73, p = .005. Similarly, the responses on the *Multicultural Counselling Awareness* (pre: M = 51.11, SD = 12.24; post: M =60.11, SD = 8.78), *Multicultural Counselling Knowledge* (pre: M = 22.20, SD = 5.05; post: M = 30.50, SD =5.33) and *Multicultural Counselling Skills* (pre: 31.60, SD = 5.50, post: M = 38.40, SD = 5.33) were also compared. Results indicated significant changes as an effect of QTMHC training on the *Multicultural Counselling Awareness, t* (9) = -2.42, p = .03, *Multicultural Counselling Knowledge, t* (9) = -3.42, p= .008, and *Multicultural Counselling Skills, t* (9) = -3.71, p = .005.

Discussion

Previous multicultural competency instruments have been conceptually limited and found to be insufficient to evaluate the training programs due to their lack of uniformity in what is being assessed by these scales (Kitaoka, 2005). The present study developed a scale to assess the efficiency of a particular multicultural training program run in Queensland, the QTMHC training program. The MMHAS was designed to provide a psychometrically sound instrument to successfully assess the effectiveness of the QTMHC training program. To ensure that the MMHAS items were developed based on the QTMHC training program objectives, these items were carefully scrutinised and analysed to allow evaluation of multicultural counselling

competencies. In the process of completing the scale the test takers were referred clearly to CALD clients as the population of interest (Kitaoka, 2005). Results indicated a scale with 35 items and three factors with moderate to high factor loadings and satisfactory psychometric properties. The three factors found to be interrelated consisted of: *Multicultural Counselling Awareness, Multicultural Counselling Knowledge,* and *Multicultural Counselling Skills.*

Factors of the MMHAS

The *Multicultural Counselling Awareness* factor of the MMHAS characterises professionals' awareness of how their cultural background may influence the service they provide to CALD consumers. This is consistent with Sue et al.'s (1982) definition of the beliefs/attitude characteristic that identifies a counselling psychologist's sensitivity towards the influences culture may create in their work with minorities. These items also reflect the impact of CALD consumers' cultural beliefs on the counselling process. This is a characteristic, which is unique to this MMHAS factor, as previous reports have indicated CALD consumers' cultural beliefs to fall in the knowledge domain of multicultural counselling competencies (Arredondo et al., 1996; Sue et al., 1992; McRae & Johnson, 1991). Overlap of domains, however, is evident in the literature (LaFromboise et al., 1991) and in the critical reviews that identify the lack of uniformity of subscales of multicultural measures (Coleman, 1998; Constantine et al., 2002; Constantine & Ladany, 2000).

The *Multicultural Counselling Knowledge* factor of the MMHAS consists of items reflecting understanding of national policies and services, programs, community linkages, and CALD individuals' barriers to access these. These characteristics are consistent with the other descriptions included in the Knowledge domain proposed by Sue et al. (1982) and confirm that

other types of knowledge in addition to CALD consumers' culture are important in treatment of their mental health problems.

The *Multicultural Counselling Skills* factor of the MMHAS characterises professionals' abilities in their work with CALD individuals. Items in this subscale generally parallel all characteristics of Sue et al.'s (1982) Skill domains such as being able to communicate effectively with the CALD clients in order to translate the gathered information into a culturally correct intervention strategy. This factor of the MMHAS is unique as it not only reflects language issues (Sue et al., 1982) and correct intervention strategies (Sue et al., 1992), it also assesses abilities to address service barriers and to work with interpreters. It is evident in the literature that apart from the competency of mental health professionals, CALD individuals' language issues, beliefs and lack of awareness pose barriers to mental health service utilisation by CALD individuals (Gorman et al., 2003; Rao et al., 2006; Thompson et al., 2002; Wynaden et al., 2005) and it is therefore important to address this in the work mental health professionals carry out with them.

A correlation among the subscales suggested an underlying domain of general multicultural counselling competency, which was similar to previous findings where a unidimensional structure was a result of the high degree of intercorrelation among the domains (LaFromboise et al., 1991; Sodowsky et al., 1994). This domain may reflect mental health professionals' self-perceived level of multicultural competency, which has been hypothesised in the literature (Constantine & Ladany, 2000; LaFromboise et al., 1991; Sodowsky et al., 1994). Counsellors' global self-evaluation of being a multicultural counsellor influences the assessment of their own particular competencies, therefore affecting factor correlations (Sodowsky et al., 1994).

The subscales in the MMHAS were generally in line with the multicultural counselling competencies introduced by Sue et al. (1982; i.e., Beliefs/Attitude, Knowledge, and Skills) however they exhibit unique features in the Awareness and Knowledge subscales. These special features indicated that the Awareness domain may be characterised as professionals' awareness of the impact that culture, from both consumer and provider, has on therapy. This overcomes the limitation in the previous scales, which focused more on "client based" awareness (Kitaoka, 2005). In addition, the Knowledge domain focused on information regarding national multicultural policies and services relevant to CALD individuals.

Psychometric Properties

Psychometric analyses were conducted on MMHAS to ensure the reliability and validity of the scale. High Cronbach's coefficient alphas suggested that the items are interrelated and consistently reflected a theme. High correlations in the test-retest reliability indicated stability of the measured multicultural counselling competencies over time. Overall, MMHAS emerged as a stable and consistent scale with little error (Coakes, Steed, & Dzidic, 2006; Green & Salkind, 2005). Validity of the MMHAS was determined by concurrent and discriminant validity. The MMHAS subscales had low to moderate correlations with the MAKSS subscales, indicating that the MMHAS represent a construct similar to the one measured by MAKSS. However, the low to moderate correlations suggest that the MMHAS has its own unique features and cannot be considered a duplicate instrument of the MAKSS. The validity of the MMHAS was also assessed by comparing scores of participants with previous multicultural counselling training and those without previous multicultural training. The MMHAS was able to discriminate those who have no multicultural competency training from those who had undergone a previous multicultural training experience. Further, a preliminary analysis of professionals who have undertaken the

QTMHC training program indicated that the scale was effective in identifying the improvement in the multicultural counselling competencies as a result of the training.

Limitations and Future Directions

Although the results are promising, the scale is still in its initial stages and requires further investigations. It is important to note that social desirability was not controlled in the study. The literature suggests that especially with instruments such as multicultural counselling competencies, some participants may attempt to overemphasise themselves as more culturally sensitive than what they are in reality (Constantine & Ladany, 2000). Future studies should add a social desirability scale with the MMHAS to detect bias. In addition, data for the test-retest reliability was obtained from a small number of participants. Future studies should conduct an analysis of the scale's test-retest validity with a larger sample of professionals to ensure generalisability of temporal stability. Although some preliminary findings are supporting discriminant validity of the scale and its ability to measure changes in the multicultural counselling competencies as a result of training, more rigorous investigation is warranted. The authors are currently involved in pursuing these questions. It is also important to note that those who volunteered to participate may have been more interested in the area and may have had a higher level of multicultural counselling competencies compared to the general population of mental health professionals. Only future studies with large samples can resolve these concerns. Additionally, keeping in view the cultural diversity in Australia, the scale can be adapted to evaluate the cultural competencies required to work with the Aboriginal and Torres Strait Islander clients.

Conclusions

This study demonstrates that the MMHAS, designed to assess the efficiency of the QTMHC training program, is a reliable and valid measure of multicultural counselling competencies. This unique instrument matches the goals and objectives of the QTMHC training program and can therefore evaluate outcomes of this training. The MMHAS may be a useful addition to the multicultural counselling literature on the nature of each competency and in future studies of multicultural counselling competencies.

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Table 1

Demographic Variables Frequencies

Variables	*n*	%
Gender		
Males	73	27
Females	190	71
Missing	5	20
Marital Status		
Married	123	46
Single	64	24
Divorced	12	5
Cohabiting	53	20
Same-sex Relationship	4	1
Missing	12	4
Occupation		
Clinical Psychologists	47	18
Counsellors	11	4
Social Workers	6	2
Trainee Psychologist	91	34
Other	106	39
Missing data	7	3
Education		
Grade 12	5	2
Tafe	3	1
Bachelor	74	29
Postgraduate degree	59	23
Master's degree	78	9
PhD	25	9
Other mental health courses	17	6
Missing data	7	26
Multicultural training		
No	140	52
Missing data	7	3
Yes	121	45
40 hours or more	26	10
20-39 hours	24	9
10-19 hours	14	5
Less than 10 hours	57	21

Ethnicity		
Anglo Saxon	171	66
Asian	32	12
Latin	14	5
Middle Eastern	4	2
African	5	2
European	18	7
Other	11	4
Missing data	7	2

Note: $N = 268$

Table 2.

Factor Loading for the Final Three-Factor Structure of the MMHAS

Item No.	Item summary	Factor loadings 1	2	3
Awareness				
18	Aware of cultural bias inherent in tools and instruments	.96		
19	Aware how CALD consumers' assumptions about therapy may affect treatment	.90		
15	Awareness how cultural beliefs impact on the therapeutic relationship	.90		
16	Understanding of how language and culture affect clinical assessment	.83		
20	Awareness how cultural beliefs impact on treatment	.83		
17	Understanding of effects of language and culture on diagnosis	.82		
14	Familiarity of how cultural barriers impact on therapy	.80		
23	Understanding of the connection between cultural identity and mental health	.66		
21	Aware of how working with traumatised clients may affect me	.66		
24	Aware of CALD consumers' difficulties due to second language proficiency	.59		
12	Understanding of how my own cultural background influences my work with CALD consumers	.57		
22	Understanding of the stressors families experience as a result of post-migration and adaptation	.52		
13	Aware of how a CALD consumer's	.48	.40	

	culture impacts on his/her mental health		
1	Knowledge of various cultures	.41	
2	Knowledge of acculturation	.38	
Knowledge			
5	Understanding of Australia's Multicultural Policy		.89
6	Knowledge of the settlement and support services provided to CALD consumers		.85
8	Knowledge about the Government policies regarding cultural diversity and service provision		.84
9	Knowledge of frameworks for developing culturally responsive services		.72
4	Knowledge of Australia's Immigration Program		.70
11	Familiarity with the advantages and disadvantages of each mental health service models for CALD consumers		.68
3	Familiarity with potential community linkages for CALD consumers		.66
10	Knowledge of implementing culturally responsive services to produce change		.64
7	Understanding of the major barriers to mental health services experienced by CALD consumers		.63
Skills			
26	Skills in providing clear messages		.74
25	Ability to understand speech of people with strong accents		.77

29	Ability to develop culturally appropriate response styles to meet the needs of CALD consumers and their families		.71
34	Ability to address the service barriers for CALD individuals	.33	.71
30	Skills in identifying strategies for promoting mental health with CALD consumers		.70
31	Skills in identifying strategies for preventing mental illness with CALD consumers		.69
27	Ability to negotiate with a CALD consumer a shared understanding of each other's beliefs regarding how mental illness is perceived		.67
35	Skills in working with interpreters	.32	.65
28	Ability to develop a culturally appropriate treatment plan		.61
33	Ability to respond to the needs of CALD torture and trauma survivors		.58
32	Skills in building rapport with CALD consumers		.53

Note. Loadings at or above .30 are reported. n = 221

Table 3.

Pearson-R correlation between MAKSS and MMHAS subscales

	Awareness MMHAS	Knowledge MMHAS	Skills MMHAS	Awareness MAKSS	Knowledge MAKSS	Skills MAKSS
Awareness MMHAS	-	.752	.813	.663	.659	.598
Knowledge MMHAS	-	-	.777	.622	.578	.552
Skills MMHAS	-	-	-	.620	.550	.681

Note: MAKSS = Multicultural Awareness-Knowledge- Skills Scale; Correlation is significant at the 0.01 level (2-tailed). n = 221